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# Executive Orders

## EXECUTIVE ORDER BJ 11-21

Gulf Opportunity Zone Advance Refunding Bond  
Allocation—Louisiana Local Government Environmental  
Facilities and Community Development Authority

WHEREAS, PL 109-135, also known as the Gulf Opportunity Zone Act of 2005 (hereafter “the Act”), was enacted to provide tax incentives to assist in the recovery and rebuilding efforts in certain areas affected by Hurricanes Katrina, Rita, and Wilma, and requires the Governor of the State of Louisiana (hereafter “the State”) to designate any advance refunding bonds as bonds issued pursuant to Section 1400(N) of the Act;

WHEREAS, the Louisiana Local Government Environmental Facilities and Community Development Authority, State of Louisiana (hereafter “the Issuer”) proposes to issue up to thirty million dollars (\$30,000,000) of its Sales Tax Bonds, Series 2010D (hereafter “the Bonds”) for the purpose of advance refunding a portion of the Issuer’s outstanding Sales Tax Bonds, Series 1998, which would otherwise not be able to be refunded on a tax exempt basis; and

WHEREAS, pursuant to the Act and Executive Order No. BJ 2008-16, issued on April 21, 2008, the Governor of the State of Louisiana is required to designate such Bonds as Advance Refunding Bonds under the Ceiling;

NOWTHEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The bond issue, as described in this Section, shall be and is hereby granted an allocation from the

2010 Ceiling as Advance Refunding Bonds in the amount shown:

Amount of Allocation	Name of Issuer	Name of Project
up to \$30,000,000	Louisiana Local Government Environmental Facilities and Community Development Authority	Woman’s Hospital Foundation Project Sales Tax Bond, Series 20910D

SECTION 2: The allocation granted herein shall be used only for the bond issue described in Section 1 of this Order.

SECTION 3: The allocation granted herein shall be valid and in full force and effect through December 31, 2010.

SECTION 4: All references in this Order to the singular shall include the plural, and all plural references shall include the singular.

SECTION 5: This Order is effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 16th day of December, 2010.

Bobby Jindal  
Governor

ATTEST BY  
THE GOVERNOR  
Jay Dardenne  
Secretary of State  
1101#92

# Emergency Rules

## DECLARATION OF EMERGENCY

### Student Financial Assistance Commission Office of Student Financial Assistance

#### Scholarship/Grant Programs—Academic Year (LAC 28:IV.301)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend and re-promulgate the rules of the Scholarship/Grant programs (R.S. 17:3021-3025, R.S. 3041.10-3041.15, and R.S. 17:3042.1.1-3042.8, R.S. 17:3048.1, R.S. 56:797.D(2)).

This rulemaking amends the definitions of academic year (college) and intersession to provide that the academic year (college) includes an intersession that lasts no more than 15 class days and ends no later than June 15.

The Emergency Rule is necessary to implement changes to the Scholarship/Grant programs to allow the Louisiana Office of Student Financial Assistance to effectively administer the programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible candidates. LASFAC has determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected recipients.

This Declaration of Emergency is effective December 21, 2010, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act. (SG11129E)

### Title 28 EDUCATION

#### Part IV. Student Financial Assistance—Higher Education

##### Scholarship and Grant Programs

##### Chapter 3. Definitions

##### §301. Definitions

A. Words and terms not otherwise defined in this Chapter shall have the meanings ascribed to such words and terms in this Section. Where the masculine is used in these rules, it includes the feminine, and vice versa; where the singular is used, it includes the plural, and vice versa.

\* \* \*

##### *Academic Year (College)*—

a. Through the 2007-2008 *academic year*, the two- and four-year college and university *academic year* begins with the fall term of the award year, includes the winter term, if applicable, and concludes with the completion of the spring term of the award year. Intersessions ending during the academic year are included in the academic year. The two- and four-year college and university academic year does not include summer sessions or intersessions that do not end during the academic year.

b. During the 2008-2009 academic year, the *academic year* begins with the fall term of the award year,

includes the winter term, if applicable, and concludes with the completion of the intersession immediately following the spring term of the award year. Intersessions ending during the *academic year*, including the intersession immediately following the spring term, are included in the academic year. The two- and four-year college and university academic year does not include summer sessions or other intersessions.

c. Beginning with the 2009-2010 academic year and thereafter, the *academic year* begins with the fall term of the award year and concludes with the completion of the spring term of the award year or the intersession immediately following the spring term if such intersession ends no later than June 15, whichever is later. Any intersession or term that begins and ends during the *academic year* is included. The two- and four-year college and university academic year does not include other intersessions or summer sessions. See the definition of “*intersession*” below.

\* \* \*

##### *Intersession*—

a. During the 2008-2009 academic year, an academic term between regular semesters/terms that provides credit courses to students in an intensive, condensed format.

b. Beginning with the 2009-2010 academic year, any academic term that provides credit courses to students in an intensive, condensed format that is no longer than 15 class days.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3025, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 24:2237 (December 1998), LR 25:256 (February 1999), LR 25:654 (April 1999), LR 25:1458 and 1460 (August 1999), LR 25:1794 (October 1999), LR 26:65 (January 2000), LR 26:688 (April 2000), LR 26:1262 (June 2000), LR 26:1601 (August 2000), LR 26:1993, 1999 (September 2000), LR 26:2268 (October 2000), LR 26:2752 (December 2000), LR 27:36 (January 2001), LR 27:284 (March 2001), LR 27:1219 (August 2001), LR 27:1840 (November 2001), LR 27:1875 (November 2001), LR 28:45 (January 2002), LR 28:446 (March 2002), LR 28:772 (April 2002), LR 28:2330, 2331 (November 2002), LR 29:555 (April 2003), LR 29:879 (June 2003), LR 30:1159 (June 2004), LR 30:2015 (September 2004), LR 31:36 (January 2005), LR 31:3112 (December 2005), LR 33:86 (January 2007), LR 33:439 (March 2007), LR 33:1339 (July 2007), LR 33:2612 (December 2007), LR 34:234 (February 2008), LR 34:1388 (July 2008), LR 34:1884 (September 2008), LR 35:228 (February 2009), LR 35:1489 (August 2009), LR 35:1490 (August 2009), LR 36:311 (February 2010), LR 36:490 (March 2010), LR 37:

George Badge Eldredge  
General Counsel

1101#026

**DECLARATION OF EMERGENCY**

**Student Financial Assistance Commission  
Office of Student Financial Assistance**

Scholarship/Grant Programs—Tuition  
(LAC 28:IV.301)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend and re-promulgate the rules of the Scholarship/Grant programs (R.S. 17:3021-3025, R.S. 3041.10-3041.15, and R.S. 17:3042.1.1-3042.8, R.S. 17:3048.1, R.S. 56:797.D(2)).

This rulemaking revises the definition of “tuition” for the purpose of determining the award amount for the Taylor Opportunity Program for Students (TOPS) beginning with the spring semester, quarter or term of the 2011-2012 award year to be either the tuition and mandatory fees as currently defined or the institution’s published tuition fee amount only, whichever is greater.

This Emergency Rule is necessary to implement changes to the Scholarship/Grant programs to allow the Louisiana Office of Student Financial Assistance and state educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. LASFAC has determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected students.

This Declaration of Emergency is effective December 21, 2010, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act. (SG11125E)

**Title 28  
EDUCATION**

**Part IV. Student Financial Assistance—Higher  
Education**

**Scholarship and Grant Programs**

**Chapter 3. Definitions**

**§301. Definitions**

A. Words and terms not otherwise defined in these rules shall have the meanings ascribed to such words and terms in this Section. Where the masculine is used in these rules, it includes the feminine, and vice versa; where the singular is used, it includes the plural, and vice versa.

\* \* \*

*Tuition—*

a. Through the fall semester or term and winter quarter of the 2010-2011 award year, the fee charged each student by a post-secondary institution to cover the student's share of the cost of instruction, including all other mandatory enrollment fees charged to all students except for the technology fee authorized by Act 1450 of the 1997 Regular Session of the Legislature:

- i. which were in effect as of January 1, 1998;
- ii. any changes in the cost of instruction authorized by the legislature and implemented by the institution after that date; and

iii. for programs with alternative scheduling formats that are approved in writing by the Board of Regents after that date. Any payment for enrollment in one of these programs shall count towards the student's maximum eligibility for his award:

(a). up to the equivalent of eight full time semesters of postsecondary education in full time semesters for the TOPS Opportunity, Performance and Honors Award; or

(b). up to the equivalent of two years of postsecondary education in full time semesters and summer sessions for the TOPS Tech Award.

b. Beginning with the spring semester, quarter or term of the 2010-2011 award year:

i. the tuition and mandatory fees authorized in subparagraph a. above; or

ii. the tuition fee amount published by the postsecondary institution, whichever is greater.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3025, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:632 (April 1998), amended LR 24:1898 (October 1998), LR 24:2237 (December 1998), LR 25:256 (February 1999), LR 25:654 (April 1999), LR 25:1458 and 1460 (August 1999), LR 25:1794 (October 1999), LR 26:65 (January 2000), LR 26:688 (April 2000), LR 26:1262 (June 2000), LR 26:1601 (August 2000), LR 26:1993, 1999 (September 2000), LR 26:2268 (October 2000), LR 26:2752 (December 2000), LR 27:36 (January 2001), LR 27:284 (March 2001), LR 27:1219 (August 2001), LR 27:1840 (November 2001), LR 27:1875 (November 2001), LR 28:45 (January 2002), LR 28:446 (March 2002), LR 28:772 (April 2002), LR 28:2330, 2331 (November 2002), LR 29:555 (April 2003), LR 29:879 (June 2003), LR 30:1159 (June 2004), LR 30:2015 (September 2004), LR 31:36 (January 2005), LR 31:3112 (December 2005), LR 33:86 (January 2007), LR 33:439 (March 2007), LR 33:1339 (July 2007), LR 33:2612 (December 2007), LR 34:234 (February 2008), LR 34:1388 (July 2008), LR 34:1884 (September 2008), LR 35:228 (February 2009), LR 35:1489 (August 2009), LR 35:1490 (August 2009), LR 36:311 (February 2010), LR 36:490 (March 2010), LR 37:

George Badge Eldredge  
General Counsel

1101#027

**DECLARATION OF EMERGENCY**

**Office of the Governor  
Division of Administration  
Racing Commission**

Mandatory Health Screening (LAC 35:I.1304)

The Louisiana State Racing Commission is exercising the emergency provisions of the Administrative Procedures Act, R.S. 49:953(B), and pursuant to the authority granted under R.S. 4:141 et seq., adopts the following emergency rule effective January 24, 2011, and it shall remain in effect for 120 days or until this rule takes effect through the normal promulgation process, whichever comes first. This

declaration extends the Emergency Rule adopted August 30, 2010 implemented on September 26, 2010.

The Louisiana State Racing Commission finds that an imminent peril to the public health, safety and welfare requires adoption of a rule upon shorter notice than that provided in R.S. 49:953(A) and within five days of adoption states in writing to the governor of the state of Louisiana, the attorney general of Louisiana, the speaker of the House of Representatives, the president of the Senate, and the Department of the State Register, its reasons for the declaration of emergency, *two wit*,

1. A number of cases of equine piroplasmiasis have recently been identified throughout the United States. Piroplasmiasis can be caused by either *Babesia cabali* or *Theileria equi*, which are protozoan parasites. The U.S. had previously been considered free of this disease.

2. It is clear from the cases identified that the U.S. is not clear of piroplasmiasis, and it continues to spread due to poor containment. There is no cure for horses testing positive for piroplasmiasis. The only options for owners of horses testing positive for piroplasmiasis are euthanasia, permanent quarantine, or sale to a country that will accept the diseased animal. The racing population is at particular risk because of the migratory nature of the industry and close stabling of horses at racetracks. Containment necessitates insuring and protecting the population of horses which are stabled at the racetrack from each other and from other horses entering the racetrack which may be carriers.

3. Cases of piroplasmiasis have been identified in race horses traveling into and out of Louisiana racetracks licensed by the Commission.

4. Presently, numerous racing jurisdictions have instituted mandatory screening/testing for piroplasmiasis. These jurisdictions include racing states of Oklahoma, Texas, New Mexico, Colorado, Florida and Iowa.

5. Horses will be migrating into Louisiana to participate in the opening of race meets which are impending and horses continue to move within the state from racetrack to racetrack.

6. Failure to institute a program of mandatory screening/testing for piroplasmiasis in Louisiana poses an imminent threat to the Louisiana racehorse population and racing industry.

**Title 35  
HORSE RACING**

**Part I. General Provisions**

**Chapter 13. Health Rules**

**§1304. Mandatory Health Screening**

A. ...

B. No horse shall be allowed to enter the confines of a racetrack of any association holding a license to conduct a race meeting or race in Louisiana unless it has had an Equine Piroplasmiasis (EP) test taken within 12 months of the date of entry upon the racetrack and/or race, with a negative result for *Theileria equi* and *Babesia caballi*. Record of the negative test shall be attached to registration papers of the horse upon entry to the racetrack. The trainer of the horse is responsible for insuring that a negative Piroplasmiasis test result is in the racing secretary's office as required by this rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:141 and R.S. 4:142.

HISTORICAL NOTE: Promulgated by Department of Commerce, Racing Commission, LR 14:226 (April 1988), amended LR 37:

Charles A. Gardiner III  
Executive Director

1101#091

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

All Inclusive Care for the Elderly  
Reimbursement Rate Reduction  
(LAC 50:XXIII.1301)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XXIII.1301 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the Program of All Inclusive Care for the Elderly (PACE) to: 1) remove the requirement that eligibility decisions be approved by the state administering agency; 2) revise PACE disenrollment criteria; 3) allow for service area specific rates instead of one statewide rate; and 4) clarify when the obligation for patient liability begins (*Louisiana Register*, Volume 33, Number 5).

As a result of a budgetary shortfall in state fiscal year 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for a PACE organization to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). Due to a continuing budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for PACE organizations to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$146,818 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions governing the reimbursement methodology for the Program of All Inclusive Care for the Elderly to reduce the reimbursement rates. seventieth

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part XXIII. All Inclusive Care for the Elderly**

**Chapter 13. Reimbursement**

**§1301. Payment**

A. - J.3. ...

K. Effective for dates of service on or after August 1, 2010, the monthly capitated amount paid to a PACE organization shall be reduced by 2 percent of the capitated amount on file as of July 31, 2010.

L. Effective for dates of service on or after January 1, 2011, the monthly capitated amount paid to a PACE organization shall be reduced by 3.09 percent of the capitated amount on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:250 (February 2004), amended LR 33:850 (May 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#006

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

Ambulatory Surgical Centers  
Reimbursement Rate Reduction  
(LAC 50:XI.7503)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XI.7503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening,

diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for ambulatory surgical centers to further reduce the reimbursement rates paid for ambulatory surgical services (*Louisiana Register*, Volume 36, Number 10). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for ambulatory surgical centers to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). The department promulgated an Emergency Rule which amended the provisions of the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:XI.7503 as a result of the promulgation of the October 20, 2010 final Rule governing ambulatory surgical centers (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has now determined that it is necessary to further reduce the reimbursement rates paid for ambulatory surgical services. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$35,466 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for ambulatory surgical centers to reduce the reimbursement rates.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part XI. Clinic Services**

**Subpart 11. Ambulatory Surgical Centers**

**Chapter 75. Reimbursement**

**§7503. Reimbursement Methodology**

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 4.4 percent of the fee amounts on file as of July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1889 (September 2009), amended LR 36:2278 (October 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of

Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#008

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

CommunityCARE Program  
Program Redesign  
(LAC 50:I.2901-2907, 2911-2913, 2917 and 2919)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:I.2901-2907, 2911-2913 and adopts 2917 and 2919 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the CommunityCARE Program to revise the payment levels for the immunization pay-for-performance initiative (*Louisiana Register*, Volume 36, Number 10). The department promulgated an Emergency Rule which amended the provisions governing primary care provider referrals and authorization in order to exempt urgent care facilities and retail convenience clinics from that requirement (*Louisiana Register*, Volume 36, Number 7). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which repealed the August 20, 2002 Rule and amended the provisions governing reimbursements to primary care providers in the CommunityCARE Program to align these reimbursements with the established fees for primary care services rendered by providers in the Professional Services Program (*Louisiana Register*, Volume 36, Number 8). The department now proposes to redesign the CommunityCARE Program by amending the provisions governing recipient participation, provider selection, provider qualifications, referrals and authorizations and primary care provider reimbursement. In addition, the department proposes to implement a pay-for-performance incentive payment methodology and a quality committee.

This action is being taken in order to avoid a budget deficit in the medical assistance programs and to improve recipient access to quality care by requiring greater provider accountability. It is anticipated that implementation of this Emergency Rule will decrease expenditures in the Medicaid

Program by approximately \$5,487,050 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the CommunityCARE Program in addition to amending the provisions contained in the July 1, 2010 and August 1, 2010 Emergency Rules.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part I. Administration

#### Subpart 3. Medicaid Coordinated Care

#### Chapter 29. CommunityCARE 2.0

#### §2901. Introduction

A. - B. ...

C. Effective January 1, 2011, the CommunityCARE Program shall hereafter be referred to as CommunityCARE 2.0 to illustrate the program redesign being implemented by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:908 (June 2003), amended LR 32:404 (March 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### §2903. Recipient Participation

A. The following groups of Medicaid recipients are mandatory enrollees in the CommunityCARE 2.0 Program:

1. TANF and TANF-related recipients;
2. SSI and SSI-related, non-Medicare, recipients who are age 19 up to age 65; and
3. CHIP recipients.

B. Effective January 1, 2011, or as soon as federal statutes allow enrollment, the following groups of Medicaid recipients may voluntarily enroll to participate in the CommunityCARE 2.0 Program:

1. Native Americans who are members of federally recognized tribes;
2. recipients who are under age 19 and are in foster care, other out-of-home placement or receiving adoption assistance;
3. recipients who are under age 19 and are eligible for SSI under Title XVI or an SSI-related group;
4. recipients who are under age 19 and are eligible through a Home and Community-Based Services Waiver; and
5. recipients receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

6. - 14.c. Repealed.

C. The following groups of recipients are excluded from participation in the CommunityCARE 2.0 Program. Individuals who:

1. are residents of:
  - a. nursing facilities;
  - b. intermediate care facilities for persons with developmental disabilities; and
  - c. psychiatric facilities;
2. are age 65 or older;
3. are dual eligibles (Medicare Part A or Part B coverage or both);

4. are refugees;
5. have other primary health insurance that covers physician benefits, including health management organizations (HMOs);
6. are receiving Hospice;
7. have eligibility less than three months or retroactive only eligibility;
8. are eligible through pregnant woman eligibility categories;
9. are eligible through CHIP Phase IV unborn option;
10. are participants in the All Inclusive Care for the Elderly (PACE) Program;
11. are under age 19 and eligible through the CHIP Affordable Plan; or
12. are eligible through the TAKE CHARGE Family Planning Waiver.

D. Requests for medical exemptions shall be reviewed for approval on a case-by-case basis for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:908 (June 2003), amended LR 32:404 (March 2006), amended LR 32:1901 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§2905. Provider Selection**

A. Recipients have the opportunity to select a participating physician, physician clinic, nurse practitioner, federally qualified health center (FQHC), or rural health clinic (RHC) located in their parish of residence or in a contiguous parish to be their primary care provider.

1. Exceptions to the PCP location requirement may be considered on a case-by-case basis based on medical need (e.g. special needs populations).

2. Recipients who do not select a PCP are automatically assigned to a participating provider.

3. The PCP shall provide basic primary care, referral and after-hours coverage services for each linked recipient. The fact that each recipient has a PCP allows continuity of care focused on the PCP as a care manager.

B. CommunityCARE 2.0 recipients may request to change primary care providers for cause at any time. The following circumstances are considered cause for changing PCPs at any time.

1. The recipient moves out of the PCP's service area.

2. Because of moral or religious objections, the PCP does not cover the service that the recipient seeks or the recipient needs related services (i.e., family planning service).

3. All related services are not available through the PCP's network of providers and it is determined by the PCP or another provider that receiving the services separately would subject the recipient to unnecessary risk.

4. Other reasons may include, but are not limited to:

- a. poor service quality;
- b. lack of access to services; or
- c. lack of access to providers with experience in dealing with the recipient's health care needs.

C. Recipients may change primary care providers without cause at any time during the first 90 days of

enrollment with a primary care provider and at least every 12 months thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and §1915(b)(1) of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 17:788 (August 1991), amended LR 19:645 (May 1993), LR 27:547 (April 2001), repromulgated LR 29:909 (June 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§2907. Provider Qualifications**

A. In order to participate in the program and qualify for the monthly PMPM base reimbursement, a primary care provider must:

1. meet all of the general Medicaid enrollment conditions;
2. be an enrolled Medicaid provider in good standing;
3. meet the CommunityCARE 2.0 participation standards; and
4. sign an attestation which documents agreement to comply with program requirements.
5. - 7. Repealed.

B. In addition, the following requirements must be met for participation.

1. A full-time equivalent (FTE) PCP must provide direct medical care a minimum of 32 hours per week at a single location.

a. During the program transition to CommunityCARE 2.0 and to afford an opportunity and time for the PCP to meet the requirement for providing a minimum of 32 hours per week of direct medical care, the PCP must attest their intent to implement this requirement by January 31, 2011 and these hours must be in place by March 31, 2011 in order for the monthly payment to be made. The base management fee will only be paid after this period if these hours have been verified.

b. If the PCP does not provide the required 32 hours of direct medical care per week as of March 31, 2011, the PCP shall be deemed in non-compliance with the participation requirements and shall be disenrolled from CommunityCARE 2.0 and all linkages will be terminated.

2. PCPs with less than 100 linkages may participate in the program, but will receive base management fee only and are not eligible to participate in the pay-for performance (P4P) pool.

a. New PCPs who have not previously participated in CommunityCARE shall be exempt from this requirement for the first 12 months of their entry into the CommunityCARE 2.0 Program.

3. PCPs or practices with linkages of 5,000 or more must have extended office hours of at least six hours per week for scheduling routine, non-urgent and urgent appointments. The extended hours may be on weekdays, weekends or a combination of both.

4. The PCP must provide an e-mail address and maintain Internet access in order to conduct administrative transactions electronically with the department.

5. The PCP must participate in the Louisiana Immunization Network for Kids Statewide (LINKS). During the program transition to CommunityCARE 2.0 and to afford an opportunity and time for the PCP to participate in the LINKS, the PCP must attest their intent to comply with this requirement by January 31, 2011. Installation and

participation must be in place by March 31, 2011 in order for the monthly payment to be made.

C. The following individual practitioners and clinics may participate as PCPs:

1. general practitioners;
2. family practitioners;
3. pediatricians;
4. gynecologists;
5. internists;
6. obstetricians;
7. federally qualified health centers; and
8. rural health clinics.

D. Other physician specialists or nurse practitioners who meet the program standards for participation may be approved by the department to be PCPs under certain circumstances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:909 (June 2003), amended LR 32:32:405 (March 2006); amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§2911. PCP Referral/Authorization**

A. The following Medicaid covered services do not require written referral/authorization by the recipient's PCP:

1. - 18. ...
19. services provided through the Office of Public Health's Women, Infants, and Children (WIC) program;
20. services provided by school based health centers to recipients age 10 and older;
21. dentures for adults;
22. services provided by urgent care facilities and retail convenience clinics.
  - a. These providers furnish walk-in, non-routine care as an alternative to emergency department care when access to primary care services is not readily available to meet the health needs of the recipient.
  - b. Urgent care facilities and retail convenience clinics must provide medical record notes of the visit to the recipient's PCP within 48 hours of the visit; and
23. effective for dates of service on or after January 1, 2011, services provided by federally qualified health centers (FQHCs).

a. These providers furnish walk-in, non-routine care as an alternative to emergency department care when access to primary care services is not readily available to meet the health needs of the recipient.

b. FQHCs must provide medical record notes of the visit to the recipient's PCP within 48 hours of the visit.

B. - B.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:909 (June 2003), amended LR 32:405 (March 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§2913. Primary Care Provider Reimbursement**

A. The management fee paid to primary care providers in the CommunityCARE Program is \$3 per enrolled recipient per month.

B. Effective for dates of service on or after August 1, 2010, primary care providers enrolled in the CommunityCARE Program shall be reimbursed at the established fees on file for professional services covered in the Professional Services Program.

C. Effective January 1, 2011, the base care management fee paid to CommunityCARE 2.0 primary care providers shall be reduced to \$1.50 per member per month to the following recipient groups:

1. TANF and TANF-related recipients; and
2. SSI and SSI-related, non-Medicare, recipients who are age 19 up to age 65; and
3. CHIP recipients.

D. Effective January 1, 2011, or as soon as federal statutes allow enrollment, a base management fee of \$1.50 per month will be paid to CommunityCARE 2.0 primary care providers per linkage to Native American recipients who are members of a federally recognized tribe.

E. Effective January 1, 2011, or as soon as federal statutes allow enrollment, the base management fee of \$3 per month will be paid to CommunityCARE 2.0 primary care providers per linkage to the following recipients:

1. recipients who have been placed in the Medicaid Lock-in Program;
2. recipients who are in foster care, other out-of-home placement, or receiving adoption assistance;
3. SSI and SSI-related recipients under age 19; and
4. recipients who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, 29:910 (June 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§2917. Pay-for-Performance Incentives**

A. Effective January 1, 2011, or as soon as federal statutes allow enrollment, a pay-for-performance payment shall be reimbursed to PCPs for linkages to recipients in the following eligibility groups as an incentive to enhance quality of care and promote provider accountability:

1. TANF and TANF related recipients;
2. SSI and SSI-related, non-Medicare, recipients who are age 19 up to age 65;
3. CHIP recipients;
4. Native American recipients who are members of a federally recognized tribe;
5. recipients who are under the age of 19 and are:
  - a. in foster care, other out-of-home placement, or receiving adoption assistance; or
  - b. eligible through SSI or SSI-related eligibility categories;
6. recipients receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs; and

7. recipients who are eligible through Home and Community-Based Services Waivers.

B. Pay-for-Performance Measures and Reimbursement

1. P4P payments will be based on a pre-determined PMPM in accordance with PCP compliance with the following performance measures and shall be reimbursed on a quarterly basis. The PCP must attest to meeting certain performance standards and the department will monitor the PCPs for program compliance.

a. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screenings. A payment of \$0.25 PMPM for recipients under the age of 21 will be made if all screenings are performed in the PCP's office.

b. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Level 1 Recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation. A payment of \$0.50 PMPM will be made if the PCP provides verification of NCQA patient centered medical home Level 1 or higher status recognition, or JCAHO primary care home accreditation.

i. During the program transition to CommunityCARE 2.0 and to afford an opportunity and time for PCPs to attain NCQA recognition or JCAHO accreditation, this payment will be made for the first three quarters based on attestation and documentation that the PCP is pursuing NCQA recognition or JCAHO accreditation.

ii. Effective for the quarter beginning October 1, 2011, payment will be contingent on the PCP providing verification of NCQA recognition or JCAHO accreditation no later than the last month of the quarter.

c. Extended Office Hours. A quarterly payment of \$0.75 PMPM will be made if the PCP meets the extended office hours requirement and provides scheduling for routine, non-urgent and urgent appointments during these hours.

i. The extended office hours must be at a minimum:

(a). six hours per week if the PCP has over 5,000 linkages;

(b). four hours per week if the PCP has from 2,000 to 5,000 linkages; and

(c). 2 hours per week if the PCP has less than 2,000 linkages.

ii. PCPs must attest to their intent to implement extended office hours by January 31, 2011.

iii. Extended office hours must be in place by March 31, 2011 in order for the first quarterly payment to be made. Payment for the second quarter will only be paid if extended office hours are verified.

d. Emergency Room Utilization. A quarterly payment will be implemented as an incentive to decrease inappropriate utilization and the need for emergency room (ER) services by CommunityCARE 2.0 recipients. Compliance will be measured through claims data.

i. A payment of \$0.75 PMPM will be made if ER utilization by linked recipients is in the lowest quartile (below the twenty-fifth percentile) for utilization of ER levels 1 and 2 for the reporting quarter.

ii. A payment of \$0.50 PMPM will be made if ER utilization by linked recipients is in the second lowest quartile (twenty-sixth to fiftieth percentile) for utilization of ER levels 1 and 2 for the reporting quarter.

iii. A payment of \$0.25 PMPM will be made if ER utilization by linked recipients is in the third lowest quartile (the fifty-first to seventy-fifth percentile) for utilization of ER levels 1 and 2 for the reporting quarter. For the first six months of the program, a PCP ranking in the third lowest quartile will be eligible for payment. After six months in the third lowest quartile, the PCP will not qualify for a payment.

C. Pay-for Performance Incentive Pool

1. Funds shall be set aside for disbursement of P4P payments to participating PCPs who meet the participation requirements and performance measures set forth in this Chapter.

2. The P4P payments will be on a per member per month (PMPM) basis and will be reimbursed to qualified PCPs on a quarterly basis (the month following the end of the performance measurement quarter).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**§2919. CommunityCARE 2.0 Quality Committee**

A. A quality committee will be established by the department to advise the secretary concerning health care quality, on-going quality improvement opportunities and recommendations for changes in the distribution of the pay-for-performance pool.

B. The committee shall consist of 15 members appointed by the secretary and will include representatives of stakeholders and providers as well as departmental staff. The committee shall be chaired by the Medicaid medical director and staffed by the department.

C. The CommunityCARE 2.0 Quality Committee shall meet, at a minimum, the first month of each quarter and as deemed necessary by the secretary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#018

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Disproportionate Share Hospital Payments Low Income and Needy Care Collaboration (LAC 50:V.2503 and 2713)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.2503 and adopts §2713 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953.B(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repromulgated all of the Rules governing the disproportionate share hospital (DSH) payment methodology in LAC 50:V.Chapters 25 and 27 (*Louisiana Register*, Volume 34, Number 4). The department amended the provisions governing disproportionate share hospital payments to provide for a supplemental payment to hospitals that enter into an agreement with a state or local governmental entity for the purpose of providing healthcare services to low income and needy patients (*Louisiana Register*, Volume 36, Number 1). The department now proposes to amend the provisions of the January 20, 2010 Emergency Rule to revise the participation requirements for the Low Income and Needy Care Collaboration. This action is being taken to secure new federal funding and to promote the public health and welfare of uninsured individuals by assuring that hospitals are adequately reimbursed for furnishing uncompensated care.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the January 20, 2010 Emergency Rule governing disproportionate share hospital payments.

#### Title 50

#### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Medical Assistance Program—Hospital Services

#### Subpart 3. Disproportionate Share Hospital Payments

#### Chapter 25. Disproportionate Share Hospital Payment Methodologies

#### §2503. Disproportionate Share Hospital Qualifications

A. - A.5. ...

6. effective September 15, 2006, be a non-rural community hospital as defined in §2701.A.;

7. effective January 20, 2010, be a hospital participating in the Low Income and Needy Care Collaboration as defined in §2713.A.; and

8. effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:655 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## Chapter 27. Qualifying Hospitals

### §2713. Low Income and Needy Care Collaboration

#### A. Definitions

*Low Income and Needy Care Collaboration Agreement*—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

B. In order to qualify under this DSH category in any period, a hospital must be party to a Low Income and Needy Care Collaboration Agreement with the Department of Health and Hospitals in that period.

C. DSH payments to Low Income and Needy Care Collaborating Hospitals shall be calculated as follows.

1. In each quarter, the department shall divide hospitals qualifying under this DSH category into two pools. The first pool shall include hospitals that, in addition to qualifying under this DSH category, also qualify for DSH payments under any other DSH category. Hospitals in the first pool shall be eligible to receive DSH payments under §2713.C.2 provisions. The second pool shall include all other hospitals qualifying under this DSH category. Hospitals in the second pool shall be eligible to receive DSH payments under §2713.C.3 provisions.

2. In each quarter, to the extent the department appropriates funding to this DSH category, hospitals that qualify under the provisions of §2713.C.2 shall receive 100 percent of the total amount appropriated by the department for this DSH category.

a. If the net uncompensated care costs of these hospitals exceed the amount appropriated for this pool, payment shall be made based on each hospital's pro rata share of the pool.

i. The pro rata share shall be calculated by dividing the hospital's net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under §2713.C.2 and multiplying by the amount appropriated by the department.

b. If the amount appropriated for this DSH category exceeds the net uncompensated care costs of all hospitals qualifying under §2713.C.2, payment shall be made up to each hospital's net uncompensated care costs.

c. Any amount available after all distributions are made under §2713.C.2 provisions shall be distributed subject to the provisions in §2713.C.3.

3. In each quarter, to the extent distributions are available, and after all distributions are made under §2713.C.2 provisions, distributions under §2713.C.3 provisions shall be made according to the following terms.

a. If the net uncompensated care costs of all hospitals qualifying for payment under §2713.C.3 provisions exceed the amount available for this pool, payment shall be made based on each hospital's pro rata share of the pool.

i. The pro rata share shall be calculated by dividing its net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under §2713.C.3.

b. If the amount available for payments under §2713.C.3 exceeds the net uncompensated care costs of all qualifying hospitals, payments shall be made up to each hospital's net uncompensated care costs and the remaining amount shall be used by the department to make

disproportionate share payments under this DSH category in future quarters.

D. In the event it is necessary to reduce the amount of disproportionate share payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the department shall calculate a pro rata decrease for each hospital qualifying under the provisions of §2713.C.3.

1. The pro rata decrease shall be based on a ratio determined by:

a. dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under §2713.C.3 in that quarter; and

b. multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

2. If necessary in any quarter, the department will reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

E. After the reduction in §2713.D has been applied, if it is necessary to further reduce the amount of DSH payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the department shall calculate a pro rata decrease for each hospital qualifying under §2713.C.2.

1. The pro rata decrease shall be based on a ratio determined by:

a. dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under §2713.C.2 in that quarter; and

b. multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

2. If necessary in any quarter, the department shall reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

F. Qualifying hospitals must submit costs and patient specific data in a format specified by the department. Costs and lengths of stay will be reviewed for reasonableness before payments are made.

G. Payments shall be made on a quarterly basis, however, each hospital's eligibility for DSH and net uncompensated care costs shall be determined on an annual basis.

H. Payments to hospitals qualifying under this DSH category shall be made subsequent to any DSH payments for which a hospital is eligible under another DSH category.

I. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit. The remaining payments shall be redistributed to the other hospitals in accordance with these provisions.

J. If the amount appropriated for this DSH category exceeds the specific DSH limits of all qualifying hospitals, payment will be made up to each hospital's specific DSH limit and the remaining amount shall be used by the

department to make disproportionate share payments under this DSH category in future quarters.

K. Effective for dates of service on or after January 1, 2011, all parties that participate in Medicaid DSH payments under this Section, either as a qualifying hospital by receipt of Medicaid DSH payments or as a state or local governmental entity funding Medicaid DSH payments, must meet the following conditions during the period of their participation.

1. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

2. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that has a direct or indirect relationship to Medicaid payments and would violate federal law.

3. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

4. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

5. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement.

6. A participating hospital may not return any of the Medicaid DSH payments it receives under this Section to the governmental entity that provides the non-federal share of the Medicaid DSH payments.

7. A participating governmental entity may not receive any portion of the Medicaid DSH payments made to a participating hospital under this Section.

L. Each participant must certify that it complies with the requirements of §2713.K by executing the appropriate certification form designated by the department for this purpose. The completed form must be submitted to the Department of Health and Hospitals, Bureau of Health Services Financing.

M. Each qualifying hospital must submit a copy of its Low Income and Needy Care Collaboration Agreement to the department.

N. The Medicaid DSH payments authorized in LAC 50:V.Subpart 3 shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for

responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#029

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment  
Dental Program  
Reimbursement Rate Reduction  
(LAC 50:XV.6903)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50: XV.6903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for dental services in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program to reduce the reimbursement fees (*Louisiana Register*, Volume 36, Number 9).

As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for EPSDT dental services to further reduce the reimbursement rates. In addition, this emergency rule also amended the provisions governing the covered services and reimbursement methodology for the EPSDT Dental Program to include an additional dental procedure (*Louisiana Register*, Volume 36, Number 8). The department promulgated an Emergency Rule which amended the provisions of the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:XV.6905 as a result of the promulgation of the September 20, 2010 final Rule governing EPSDT dental services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for EPSDT dental services to further reduce the reimbursement rates.

This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$1,058,955 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for EPSDT dental services to reduce the reimbursement rates.

### Title 50

## PUBLIC HEALTH—MEDICAL ASSISTANCE

### Part XV. Services for Special Populations

#### Subpart 5. Early and Periodic Screening,

#### Diagnosis and Treatment

### Chapter 69. Dental Services

#### §6905. Reimbursement

A. - D.3. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 69 percent for the following oral evaluation services:
  - a. periodic oral examination;
  - b. oral examination—patients under three years of age; and
  - c. comprehensive oral examination—new patient;
2. 65 percent for the following annual and periodic diagnostic and preventive services:
  - a. radiographs—periapical, first film;
  - b. radiograph—periapical, each additional film;
  - c. radiograph—panoramic film;
  - d. prophylaxis—adult and child;
  - e. topical application of fluoride—adult and child (prophylaxis not included); and
  - f. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);
3. 50 percent for the following diagnostic and adjunctive general services:
  - a. oral/facial images;
  - b. non-intravenous conscious sedation; and
  - c. hospital call; and
4. 58 percent for the remainder of the dental services.

F. Removable prosthodontics and orthodontic services are excluded from the August 1, 2010 rate reduction.

G. Effective for dates of service on and after January 1, 2011, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 67.5 percent for the following oral evaluation services:
  - a. periodic oral examination;
  - b. oral Examination-patients under 3 years of age; and
  - c. comprehensive oral examination-new patients;
2. 63.5 percent for the following annual and periodic diagnostic and preventive services:

- a. radiographs-periapical, first film;
- b. radiographs-periapical, each additional film;
- c. radiographs-panoramic film;
- d. diagnostic casts;
- e. prophylaxis-adult and child;
- f. topical application of fluoride, adult and child (prophylaxis not included); and
- g. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 73.5 percent for accession of tissue, gross and microscopic examination, preparation and transmission of written report;

4. 70.9 percent for accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report;

5. 50 percent for the following diagnostic and adjunctive general services:

- a. oral/facial image;
- b. non-intravenous conscious sedation; and
- c. hospital call; and

6. 57 percent for the remainder of the dental services.

H. Removable prosthodontics and orthodontic services are excluded from the January 1, 2011 rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1138 (June 2007), amended LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1890 (September 2009), amended LR 36:2040 (September 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#001

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment  
Health Services  
EarlySteps Reimbursement Rate Reduction  
(LAC 50:XV.7107)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.7107 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the

Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of the allocation of additional funds during the 2008 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) health services to increase the reimbursement rates paid for certain services rendered to infants and toddlers in the EarlySteps Program (*Louisiana Register*, Volume 35, Number 1). As a result of a budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to reduce the reimbursement rates paid for certain EPSDT health services rendered in the EarlySteps Program. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$56,649 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Early and Periodic Screening, Diagnosis and Treatment health services provided through the EarlySteps Program to reduce the reimbursement rates.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part XV. Services to Special Populations

#### Subpart 5. Early and Periodic Screening, Diagnosis and Treatment

#### Chapter 71. Health Services

#### §7107. EarlySteps Reimbursement

A. - B.2.e. ...

C. Effective for dates of service on or after January 1, 2011, the reimbursement for certain Medicaid-covered health services rendered in the EarlySteps Program shall be reduced by 2 percent of the rate in effect on December 31, 2010.

1. The following services rendered in the natural environment shall be reimbursed at the reduced rate:

- a. audiology services;
- b. speech pathology services;
- c. occupational therapy;
- d. physical therapy; and
- e. psychological services.

2. Services rendered in special purpose facilities/inclusive child care and center-based special purpose facilities shall be excluded from this rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:800 (April 2004), amended LR 31:2030 (August 2005), LR 35:69 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#009

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

End Stage Renal Disease Facilities  
Reimbursement Rate Reduction  
(LAC 50:XI.6901 and 6903)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XI.6901 and §6903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for end stage renal disease (ESRD) facilities to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 9). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for ESRD facilities to further reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). The department promulgated an Emergency Rule which amended the provisions of the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:XI.6901-6903 as a result of the

promulgation of the September 20, 2010 final Rule (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for ESRD facilities to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$209,684 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for end stage renal disease facilities to reduce the reimbursement rates.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part XI. Clinic Services

##### Subpart 9. End Stage Renal Disease Facilities

#### Chapter 69. Reimbursement

##### §6901. General Provisions

A. End stage renal disease (ESRD) facilities are reimbursed a hemodialysis composite rate. The composite rate is a comprehensive payment for the complete hemodialysis treatment in which the facility assumes responsibility for providing all medically necessary routine dialysis services.

B. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities shall be reduced by 2 percent of the rates in effect on December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1022 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1891 (September 2009), LR 36:2040 (September 2010), LR 37:

##### §6903. Medicare Part B Claims

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 2 percent of the rates in effect on December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1891 (September 2009), amended LR 36:2040 (September 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#012

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Greater New Orleans Community Health Connection Waiver (LAC 50:XXII.Chapters 61-69)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:XXII.Chapters 61-69 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 (B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

In July 2007, the Department of Health and Hospitals was awarded a \$100 million Primary Care Access Stabilization Grant (PCASG) from the Department of Health and Human Services, Centers for Medicare and Medicaid Services as a result of the disruption of primary health care service delivery in the greater New Orleans area due to Hurricanes Katrina and Rita. The PCASG was a three-year grant program designed to restore and expand access to primary care services, including behavioral health and dental services, without regard to a patient's ability to pay. The intent of the program was to restore and stabilize the provision of primary health care services in the New Orleans area by providing short-term financial relief to providers and to decrease reliance on costly emergency room services for patients who were uninsured, underinsured, or receiving Medicaid benefits. The PCASG program will end on September 30, 2010.

As a result of the termination of PCASG funds, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which implemented a demonstration program under the authority of a Section 1115 Waiver to ensure continued access to primary and behavioral health care services that were restored and expanded in the greater New Orleans area (*Louisiana Register*, Volume 36, Number 10). Under this demonstration waiver, the Medicaid Program will provide coverage for primary and behavioral health care services delivered to eligible residents in Jefferson, Orleans, Plaquemines and St. Bernard parishes who have family income up to 200 percent of the federal poverty level. This Emergency Rule is being promulgated to continue the provisions of the October 1, 2010 Emergency Rule. This action is being taken to protect the health and welfare of uninsured individuals in the greater New Orleans area by ensuring continued access to primary care services.

Effective January 30, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing adopts the following provisions to implement a Section 1115 demonstration waiver to ensure continued access to primary and behavioral health care services in the greater New Orleans area.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part XXII. 1115 Demonstration Waivers

##### Subpart 7. Greater New Orleans Community Health Connection Waiver

#### Chapter 61. General Provisions

##### §6101. Purpose

A. Upon approval from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Department shall implement a Section 1115 demonstration waiver called the Greater New Orleans Community Health Connection (GNOCHC) Waiver to provide primary and behavioral health care services to eligible uninsured residents in the greater New Orleans area.

B. The intent of the GNOCHC Waiver is to preserve primary and behavioral health care access that was restored and expanded in the greater New Orleans area with Primary Care Access and Stabilization Grant (PCASG) funds awarded by CMS after Hurricanes Katrina and Rita. Implementation of this waiver program is expected to reduce reliance on costlier emergency room services to meet primary care needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

##### §6103. Program Design

A. The GNOCHC Waiver is designed to transition the PCASG medical home model to a financially sustainable model utilizing other funding resources over the long-term.

B. The waiver is a 39 month demonstration project which shall be implemented in two primary phases which span four fiscal years.

C. Phase one of the GNOCHC Waiver shall focus on preserving access to primary care services and developing a CMS approved plan for transitioning the funding of the demonstration project to long-term revenue sources. Phase two focuses on implementing the transition plan, assessment, and the demonstration project phase-down.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### Chapter 63. Eligibility

##### §6301. General Provisions

A. The targeted population for GNOCHC Waiver services shall be uninsured adults who live in the greater New Orleans area. For purposes of these provisions, the greater New Orleans area shall consist of the following parishes:

1. Jefferson;
2. Orleans;
3. Plaquemines; and
4. St. Bernard.

B. All applicants shall be pre-screened to determine possible eligibility for coverage in other Medicaid or

Children's Health Insurance Programs (CHIP) prior to determining eligibility for GNOCHC Waiver services.

C. Retroactive coverage is not available in the GNOCHC Waiver program. The effective date of coverage for eligible recipients shall be the date the Medicaid Program receives the application for services.

D. At the department's discretion and upon CMS approval, the following measures may be taken to manage eligibility for these services to ensure that waiver expenditures do not exceed funding allocations. The department may:

1. employ a first come, first served reservation list to manage the number of applications received;
2. limit the number of applications provided to potential recipients; or
3. impose enrollment limits;

E. Waiver recipients shall undergo an eligibility redetermination at least once every 12 months. Each redetermination shall include an assessment of the individual's eligibility for coverage in other Medicaid or CHIP programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§6303. Recipient Qualifications**

A. GNOCHC Waiver services shall be provided to individuals who:

1. have been uninsured for at least 6 months;
2. are not pregnant;
3. are age 19 through 64 years old;
4. are not otherwise eligible for Medicaid, CHIP or Medicare coverage;
5. are a resident of any one of the parishes in the greater New Orleans area as defined in §6301.A;
6. have family income up to 200 percent of the federal poverty level; and
7. meet citizenship requirements under the Deficit Reduction Act of 2008 and the Children's Health Insurance Program Reauthorization Act of 2009.

B. A waiver recipient shall be disenrolled from the program if any one of the following occurs. The recipient:

1. has family income that exceeds the income limits at redetermination;
2. voluntarily withdraws from the program;
3. no longer resides in a parish within the greater New Orleans area;
4. becomes incarcerated or becomes an inpatient in an institution for mental disorders;
5. obtains health insurance coverage;
6. turns 65 years old; or
7. dies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## **Chapter 65. Services**

### **§6501. Covered Services**

A. The following services shall be available to GNOCHC Waiver recipients:

1. care coordination;
2. immunizations and influenza vaccines;
3. laboratory and radiology;

4. behavioral health care;
5. pharmacy;
6. primary health care;
7. preventive health care;
8. substance abuse; and
9. specialty care (covered with a referral from the primary care physician).

B. Cost-sharing may be applicable to the services rendered in this waiver program. All demonstration cost-sharing shall be in compliance with federal statutes, regulations and policies. A waiver recipient's share of the cost shall be restricted to a 5 percent aggregate limit per family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§6503. Service Delivery**

A. All of the covered services under this waiver program shall be delivered by an existing PCASG funded clinic.

B. All services shall be delivered on an outpatient basis. Reimbursement shall not be made under this waiver program for services rendered to recipients who meet inpatient status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## **Chapter 67. Provider Participation**

### **§6701. General Provisions**

A. All clinics participating in the delivery of services covered under the GNOCHC Waiver shall adhere to all of the applicable federal and state regulations, policy, Rules, manuals and laws.

B. Each participating clinic shall meet the following requirements. The clinic shall:

1. be an existing PCASG funded clinic;
2. be operational and serving waiver recipients on October 1, 2010;
  - a. if a former PCASG clinic wishes to reestablish operations as a GNOCHC participating clinic after October 1, 2010, CMS approval shall be required;
  3. be a public or private not-for-profit entity that meets the following conditions:
    - a. the entity must not be an individual practitioner in private solo or group practice;
    - b. the clinic shall be currently licensed, if applicable;
    - c. either the clinic or its licensed practitioners shall be currently enrolled in the Medicaid Program; and
    - d. all health care practitioners affiliated with the clinic that provide health care treatment, behavioral health counseling, or any other type of clinical health care services to patients shall hold a current, unrestricted license to practice in the state of Louisiana within the scope of that licensure;
  4. provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, partnerships, etc.;
  5. have a statutory, regulatory or formally established policy commitment (e.g. through corporate bylaws) to serve all people, including patients without insurance, at every income level regardless of their ability to pay for services,

and be willing to accept and serve new publicly insured and uninsured individuals;

6. maintain one or more health care access points or service delivery sites for the provision of health care services which may include medical care, behavioral health care and substance abuse services, either directly on-site or through established contractual arrangements; and

7. be capable of implementing and evaluating the effectiveness of an organization-specific strategic plan to become a sustainable organizational entity by December 31, 2013 which is capable of permanently providing primary or behavioral health care services to residents in the greater New Orleans area.

a. For purposes of these provisions, a sustainable organizational entity shall be defined as an entity actively developing, implementing and evaluating the effectiveness of its organization to diversify its operating income and funding resources to include non-demonstration funding sources.

C. Participating providers/clinics shall be responsible for:

1. collection of all data on the services rendered to demonstration participants through encounter data or other methods so specified by the department; and

2. maintenance of such data at the provider level.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§6703. Reporting Requirements**

A. GNOCHC participating clinics shall be required to provide a sustainability plan to the department by March 1, 2011.

B. Semi-annual progress reports on the sustainability plan shall be submitted during the second and fourth quarter of each demonstration year. The first annual report is due in the fourth quarter of the first demonstration year.

C. Participating providers/clinics shall be required to provide encounter data in the format and frequency specified by the department.

D. Clinics that do not comply with these reporting requirements shall not be eligible to receive payments from this demonstration program and may receive financial penalties for noncompliance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## **Chapter 69. Reimbursement**

### **§6901. General Provisions**

A. Clinics shall ensure that reimbursement for services covered under the GNOCHC Waiver is requested only for those individuals who meet the program criteria.

B. Federal financial participation (FFP) for this waiver program is limited to the federal share of \$30 million annually in demonstration expenditures in each of the first three years of the demonstration. In year four, FFP is limited to the federal share of \$7.5 million. Thus, the total FFP for this demonstration waiver program over all four years is limited to the federal share of \$97.5 million. Federal funding will not be available for expenditures in excess of these annual limits even when the expenditure limit was not reached in prior years.

1. These provisions do not preclude the department from including as allowable expenditures for a particular demonstration year any expenditures incurred after the end of a demonstration year for items or services furnished during that year.

C. The federal share of expenditures for payments to GNOCHC providers shall be calculated based upon the applicable federal medical assistance percentage rate for the year in which the expenditures were incurred.

D. The department may make an urgent sustainability payment to any eligible GNOCHC clinic that meets the criteria of this Chapter 67 and requires financial support to maintain clinical operations while the department seeks CMS approval for the funding and reimbursement protocol for this waiver program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§6903. Reimbursement Methodology**

#### **A. Urgent Sustainability Payments**

1. For each clinic requiring an urgent sustainability payment, the department shall determine the average payment based upon the clinic's three-year historical grant award received under the PCASG program.

2. The sustainability payment shall be no more than 25 percent of the average annual payment determined for that clinic during the PCASG period. Prior approval from CMS shall be required for sustainability payments in excess of 25 percent of the clinic's average PCASG payment. The department may disburse the payment in the first quarter of demonstration year one.

3. Upon CMS approval of the payment methodology, the department shall reconcile the amount of sustainability payments made to clinics during the period of October 1, 2010 through December 31, 2010 against the actual payments that would have been made to the clinics under the approved payment methodology.

a. Any overpayments made to a clinic shall be recouped from the clinic's payments due in the quarter following the reconciliation.

b. Any underpayments made to a clinic shall be made in the quarter following the reconciliation.

4. The total of all sustainability payments made during the first quarter in demonstration year one shall not exceed \$7.5 million. Any sustainability payments made shall be applied to the \$30 million total computable annual allotment for demonstration year one.

B. Reimbursement for services rendered during phase one and phase two of the demonstration shall be made according to the rate methodology established by the department and approved by CMS in the funding and reimbursement protocol for this waiver program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#078

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Home and Community-Based Services Waivers  
Elderly and Disabled Adults—Personal Assistance Services  
(LAC 50:XXI.8101, 8105, 8107,  
8301, 8503, 8901, and 8903)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amends LAC 50:XXI.8101, §8105, §8107, §8301 and §8503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 (B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

To assure compliance with federal requirements regarding the cost-effectiveness of the Elderly and Disabled Adults (EDA) Waiver Program, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the EDA Waiver to: 1) change the allocation priority of waiver opportunities; 2) implement uniform needs-based assessments to determine the level of support needs and establish an individual cost cap based on need; 3) clarify the service cap for environmental accessibility adaptation services; 4) add shared supports to companion services; and 5) mandate that personal representatives cannot be the paid companion care worker (*Louisiana Register*, Volume 35, Number 11). The department promulgated an Emergency Rule which amended the provisions governing the EDA Waiver to implement a new service that incorporated the current functions of companion services and further clarified the provisions governing responsible representatives and discharge criteria (*Louisiana Register*, Volume 36, Number 6). The July 4, 2010 Emergency Rule also reorganized the provisions governing covered services in a more clear and concise manner in the Louisiana Administrative Code.

The department promulgated an Emergency Rule which amended the provisions of the July 4, 2010 Emergency Rule to: 1) adopt provisions that address requests for services; 2) revise the provisions governing the allocation of waiver opportunities and the resource assessment process; 3) clarify the provisions governing restrictions for paid direct care staff and the place of service; and 4) revise the provisions governing provider responsibilities (*Louisiana Register*, Volume 36, Number 10). This Emergency Rule is being

promulgated to continue the provisions of the October 20, 2010 Emergency Rule. This action is being taken to avoid federal sanctions for noncompliance with waiver cost-effectiveness requirements and to ensure long-term financial viability for the Elderly and Disabled Adults Waiver.

Effective February 18, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions governing the Elderly and Disabled Adults Waiver.

### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE Part XXI. Home and Community-Based Services Waivers

#### Subpart 7. Elderly and Disabled Adults Waiver

#### Chapter 81. General Provisions

#### §8101. Introduction

A. - B. ...

C. Requests for EDA waiver services shall be accepted from the following individuals:

1. an individual who wants to receive EDA Waiver services;

2. an individual who is legally responsible for a participant who may be in need of EDA Waiver services; or

3. a responsible representative designated by the participant to act on his/her behalf in requesting EDA Waiver services.

D. Each participant who requests EDA Waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the participant to act on his/her behalf in the process of accessing and/or maintaining EDA Waiver services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the participant's business without his/her involvement.

b. The written designation is valid until revoked by the participant. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:  
a. assist and represent the participant in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all necessary documentation for these processes.

3. The participant's responsible representative shall not be reimbursed for providing services to the participant.

4. An owner or employee of a EDA Waiver services agency may not be designated as a responsible representative for any recipient who receives services from an agency he/she owns or is employed by.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1698 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department Of Health and Hospitals, Office of Aging and Adult Services, LR 34:1029 (June 2008), amended by

the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 37:

### **§8105. Programmatic Allocation of Waiver Opportunities**

A. ...

B. EDA Waiver opportunities shall be offered to individuals on the registry according to the following needs-based priority groups. The following groups shall have priority for EDA Waiver opportunities, in the order listed:

1. individuals with substantiated cases of abuse or neglect with Adult Protective Services or Elderly Protective Services who, absent EDA Waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS);

3. individuals presently residing in nursing facilities for 90 or more continuous days;

a. - NOTE. Repealed.

4. individuals who are not presently receiving home and community-based services under another approved waiver program including, but not limited to the:

a. Adult Day Health Care Waiver;

b. New Opportunities Waiver;

c. Supports Waiver; and

d. Residential Options Waiver;

5. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:1030 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 37:

### **§8107. Resource Assessment Process**

A. - C.1. ...

2. The applicant/recipient may qualify for an increase in the annual services budget amount upon showing that:

a. one or more answers are incorrect as recorded on the MDS-HC (with the exception of the answers in Sections AA, BB, A, and R of the MDS-HC); or

b. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2447 (November 2009), amended LR 37:

## **Chapter 83. Covered Services**

### **§8301. Service Descriptions**

A. Support Coordination is services that will assist recipients in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing

monitoring of the provision of services included in the recipient's approved CPOC.

B. Transition Intensive Support Coordination is services that will assist recipients who are currently residing in nursing facilities in gaining access to necessary waiver and State Plan services, as well as needed social, educational and other services, regardless of the funding source for these services. Support coordinators will initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved CPOC.

C. Environmental Accessibility Adaptation is necessary physical adaptations made to the home to ensure the health, safety, and welfare of the recipient, or enable the recipient to function with greater independence in the home. Without these necessary adaptations, the recipient would require institutionalization. These services must be provided in accordance with state and local laws governing licensure and/or certification.

1. There is a lifetime cap of \$3,000 per recipient for this service.

D. Personal Emergency Response System (PERS). This is an electronic device which enables the recipient to secure help in an emergency. PERS services are limited to specific recipients.

5. - 5.e. Repealed.

E. Personal Assistance Services (PAS) provides assistance to participants in performing the activities of daily living and household chores necessary to maintain the home in a clean, sanitary and safe environment, based on their CPOC.

1. PAS may also include the following services based on the CPOC:

a. protective supervision provided solely to assure the health and welfare of a participant with cognitive/memory impairment and/or physical weakness;

b. supervising or assisting, as approved in the CPOC, a participant with functional impairments with health related tasks (any health related procedures governed under the Nurse Practice Act) if he/she is unable to do so without supports according to applicable delegation/medication administration;

c. supervising or assisting the participant, who has no supports and is unable to do so without supports or has no available natural supports, to socialize in his/her community according to the desired outcomes included in the CPOC;

d. escort services, which are used to accompany the individual outside of the home during the performance of tasks related to instrumental activities of daily living and health maintenance, and to provide the same assistance as would be rendered in the home; and

e. extension of therapy services.

i. For purposes of these provisions, extension of therapy services may include instances where licensed practitioners may provide instruction to the worker so he/she is able to better assist the participant.

ii. Licensed therapists may choose to instruct the workers on the proper way to assist the participant in follow-up therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process.

iii. A registered nurse may instruct a worker to perform basic interventions with participants that would increase and optimize functional abilities for maximum independence in performing activities of daily living, such as range of motion exercises.

2. PAS is provided in the participant's home unless the participant requests to receive PAS outside of the home.

a. PAS shall not duplicate the services provided to a participant who resides in an assisted living facility.

b. The participant must be present while PAS services are being provided in the home.

3. Service Restrictions

a. PAS shall not be provided during the same designated hours or time period that a participant receives Adult Day Health Care services.

b. Participants who receive PAS cannot receive Long-Term Personal Care Services.

4. PAS services may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider.

a. Waiver participants may share PAS service staff when it is agreed to by the participants and health, safety and welfare can be assured for each individual.

b. Shared PAS services will be reflected on the plan of care of each participant.

5. The following individuals are prohibited from being reimbursed for providing services to a participant:

- a. the participant's spouse;
- b. the participant's curator;
- c. the participant's tutor;
- d. the participant's legal guardian;
- e. the participant's responsible representative; or
- f. the person to whom the participant has given

Representative and Mandate authority (also known as power of attorney).

6. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the participant.

F. Transition Services. These services assist an individual, who has been approved for an EDA Waiver opportunity, to leave a nursing facility and return to live in the community.

1. Service Limit. Funds are available one time per lifetime for specific items as approved in the recipient's CPOC.

G. Adult Day Health Care (ADHC). ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished for five or more hours per day (exclusive of transportation time to and from the ADHC facility) on a regularly scheduled basis for one or more days per week, or as specified in the plan of care. An adult day health care facility shall, at a minimum, furnish the following services:

- 1. individualized training or assistance with the activities of daily living (toileting, grooming, eating, ambulation, etc.);
- 2. health and nutrition counseling;
- 3. an individualized, daily exercise program;
- 4. an individualized, goal directed recreation program;
- 5. daily health education;

- 6. medical care management;
- 7. one nutritionally balanced hot meal and two snacks served each day;

8. nursing services that include the following individualized health services:

a. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;

b. administering medications and treatments in accordance with physicians' orders;

c. monitoring self-administration of medications while the recipient is at the ADHC facility; and

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

d. transportation to and from the facility.

NOTE: If transportation services that are prescribed in any participant's approved CPOC are not provided by the ADHC facility, the facility's reimbursement rate shall be reduced accordingly.

H. Providers of EDA Waiver services must have a valid, current license for their respective service program, if applicable, and furnish services in accordance with the applicable licensing and/or certification requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1245 (July 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2448 (November 2009), amended LR 37:

## **Chapter 85. Admission and Discharge Criteria**

### **§8503. Admission Denial or Discharge Criteria**

A. Admission shall be denied or the participant shall be discharged from the EDA Waiver Program if any of the following conditions are determined.

1. - 7. ...

8. It is not cost effective or appropriate to serve the individual in the EDA Waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1699 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1246 (July 2006), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:1030 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

## **Chapter 89. Provider Responsibilities**

### **§8901. General Provisions**

A. Any provider of services under the EDA Waiver shall abide by and adhere to any federal or state laws, Rules, policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving services in accordance with the EDA Waiver Program provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 30:1700 (August 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:1247 (July 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

**§8903. Reporting Requirements**

A. Support coordination and direct service providers are obligated to report changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordination and direct service providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the recipient and completing an incident report. The incident report shall be submitted to the department with the specified requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#077

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Home Health Program—Extended Nursing Services  
Reimbursement Rate Reduction  
(LAC 50:XIII.701)**

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XIII.701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other

measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing services covered in the Home Health Program to increase the reimbursement rates paid for extended nursing services (*Louisiana Register*, Volume 34, Number 4).

Due to a budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for nursing services covered in the Home Health Program in order to reduce the reimbursement rates paid for extended nursing services. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$260,944 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for extended nursing services in the Home Health Program to reduce the reimbursement rates.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part XIII. Home Health**

**Subpart 1. Home Health Services**

**Chapter 7. Reimbursement Methodology**

**§701. Nursing and Home Health Aide Services**

A. - B.3. ...

C. Effective for dates of service on or after January 1, 2011, the reimbursement rates for extended nursing services shall be reduced by 2 percent of the rates in effect on December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2281 (October 2010), amended LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#011

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Inpatient Hospital Services  
Non-Rural, Non-State Hospitals  
Low Income and Needy Care Collaboration  
(LAC 50:V.953)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.953 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953.B(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates and to provide for a supplemental Medicaid payment to hospitals that enter into an agreement with a state or local governmental entity for the purpose of providing healthcare services to low income and needy patients (*Louisiana Register*, Volume 36, Number 11).

The department now proposes to amend the provisions governing the reimbursement methodology for inpatient hospital services to revise the participation requirements for the Low Income and Needy Care Collaboration. This action is being taken to secure new federal funding and to promote the public health and welfare of Medicaid recipients by ensuring sufficient provider participation in the Hospital Services Program. It is estimated that implementation of this Emergency Rule will have no fiscal impact for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospital Services

##### Subpart 1. Inpatient Hospitals

#### Chapter 9. Non-Rural, Non-State Hospitals

##### Subchapter B. Reimbursement Methodology

#### §953. Acute Care Hospitals

A. - N.2.b. ...

3. Effective for dates of service on or after January 1, 2011, all parties that participate in supplemental payments under this Section, either as a qualifying hospital by receipt of supplemental payments or as a state or local governmental entity funding supplemental payments, must meet the following conditions during the period of their participation.

a. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

b. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that has a direct or indirect relationship to Medicaid payments and would violate federal law.

c. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

d. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

e. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement.

f. A participating hospital may not return any of the supplemental payments it receives under this Section to the governmental entity that provides the non-federal share of the supplemental payments.

g. A participating governmental entity may not receive any portion of the supplemental payments made to a participating hospital under this Section.

4. Each participant must certify that it complies with the requirements of §953.N.3 by executing the appropriate certification form designated by the department for this purpose. The completed form must be submitted to the Department of Health and Hospitals, Bureau of Health Services Financing.

5. Each qualifying hospital must submit a copy of its Low Income and Needy Care Collaboration Agreement to the department.

6. The supplemental payments authorized in this Section shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1552 (July 2010), LR 36:2561 (November 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#030

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Inpatient Hospital Services—Non-Rural, Non-State Hospitals—Outlier Payment Methodology (LAC 50:V.954)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.954 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing repromulgated all of the provisions governing outlier payments for inpatient hospital services in a codified format for inclusion in the *Louisiana Administrative Code* (*Louisiana Register*, Volume 36, Number 3).

Due to a budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to amend the provisions governing inpatient hospital services rendered by non-rural, non-state hospitals in order to revise the outlier payment methodology. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$2,573,288 for state fiscal year 2010-2011.

Effective January 1, 2011 the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services to revise the provisions governing outlier payments made to non-rural, non-state hospitals.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospital Services

#### Chapter 9. Non-Rural, Non-State Hospitals

#### Subchapter B. Reimbursement Methodology

#### §954. Outlier Payments

A. – A.2. ...

B. The marginal cost for outlier payments is considered to be hospital cost for an inpatient stay in excess of the sum of the hospital's prospective payment and any other payment made on behalf of the patient for that stay by any other payee.

1. Cost is defined as the hospital-specific cost to charge ratio based on the hospital's cost report period ending in state fiscal year 2008 (July 1, 2007 through June 30,

2008) multiplied by the total billed charges for an outlier claim.

2. For new hospitals and hospitals that did not provide Medicaid Neonatal Intensive Care Unit (NICU) services in state fiscal year 2008, the hospital-specific cost to charge ratio will be calculated based on the first full year cost reporting period that the hospital was open or that Medicaid NICU services were provided.

C. ...

D. Outlier payments to hospitals shall be made semi-annually. Payments shall be made for dates of service claims in a state fiscal year divided into six-month segments. The two segments of a fiscal year shall be the first two quarters (July through December) of the state fiscal year and the last two quarters (January through June).

1. Outlier claims with dates of service in a segment of a fiscal year which are received by the department within six months after the end of that segment shall be paid on a date not later than seven months after the end of that segment. If an outlier claim is received by the department more than six months after the end of any segment, it shall not be considered for payment in the payment cycle for that segment. However, if a valid outlier claim is received more than six months after the end of the segment, and if payments have been made to reflect each participating hospitals' pro rata share of the capped amount authorized for that segment rather than the appropriate percentage of the hospital's marginal cost, then outlier payments to all participating hospitals for that segment will be adjusted semiannually upward (additional payment) or downward (recoupment), as necessary to reflect each hospitals' pro rata share of the capped amount authorized for outlier payments for that segment. Hospitals shall split bill outlier claims that begin in one segment and end in another.

2. The hospital-specific cost to charge ratio shall be reviewed bi-annually and may be updated according to the current cost report data at the discretion of the secretary.

E. Effective for dates of service on or after January 1, 2011, if covered charges for each individual outlier case, as defined in §954.A, exceeds both \$250,000 and 200 percent of the prospective payment, reimbursement shall be the lesser of 65 percent of the hospital's marginal cost for the claim or a pro rata share of the annual amount of claims submitted by all hospitals, multiplied by the total amount authorized for outlier payments for that semi-annual segment of the state fiscal year.

F. For dates of service in the period January 1, 2011 through June 30, 2011 inclusive, the amount authorized for outlier payments is \$15,000,000. For dates of service in state fiscal year 2012 and subsequent years, the amount authorized is \$15,000,000 for each semi-annual state fiscal year segment.

G. Outlier payments are not payable for transplant procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:519 (March 2010), amended LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and

Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#004

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Inpatient Hospital Services—Non-Rural, Non-State Hospitals—Reimbursement Rate Reduction (LAC 50:V.953, 955, 959 and 967)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V. 953,955,959 and 967 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year (SFY) 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates for inpatient hospital services rendered by non-rural, non-state hospitals (*Louisiana Register*, Volume 36, Number 11). The November 20, 2010 Rule also amended the reimbursement methodology for inpatient hospital services to establish a Medicaid upper payment limit financing mechanism to provide supplemental payments to hospitals for providing healthcare services to low income and needy patients.

As a result of a budgetary shortfall in SFY 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates paid to non-rural, non-state hospitals (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule also amended the provisions governing the appeals procedure that address the criteria for qualifying loss. The department promulgated an Emergency Rule which

amended the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:V.953, §955, §959 and §967 as a result of the promulgation of the November 20, 2010 final Rule governing inpatient hospital services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for inpatient hospital services to further reduce the reimbursement rates paid to non-rural, non-state hospitals. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$3,831,446 for state fiscal year 2010-2011.

Taking the proposed per diem rate reduction into consideration, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private (non-state) inpatient hospital services and children’s specialty hospital services under the State Plan are available at least to the extent that they are available to the general population in the state.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for inpatient hospital services to reduce the reimbursement rates paid to non-rural, non-state hospitals.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospital Services

##### Subpart 1. Inpatient Hospital Services

#### Chapter 9. Non-Rural, Non-State Hospitals

##### Subchapter B. Reimbursement Methodology

#### §953. Acute Care Hospitals

A. - O.1....

P. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

Q. Effective for dates of service on or after January 1 2011, the inpatient per diem rate paid to acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1300 shall be exempt from this reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1552(July 2010), LR 36:2561 (November, 2010), LR 37:

#### §955. Long Term Hospitals

A. - F. ...

G. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to long term hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR: 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November, 2010), LR 37:

#### **§959. Inpatient Psychiatric Hospital Services**

A. - H. ...

I. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

J. Effective for dates of service on or after January 1, 2011, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November, 2010), LR 37:

#### **§967. Children's Specialty Hospitals**

A. - E. ...

1. Medicaid supplemental payments related to high cost Medicaid and graduate medical education supplemental payments shall be included as an interim Medicaid inpatient payment in the determination of cost settlement amounts on the filed cost report.

F. Effective for dates of service on or after February 3, 2010, the per diem rates as calculated per §967.A-C above shall be reduced by 5 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care and psychiatric costs as determined by the cost report or the Medicaid discharges or days as specified per §967.A-C for the period, multiplied by 95 percent of the target rate per discharge or per diem limitation as specified per §967.A-C for the period.

G. Effective for dates of service on or after August 1, 2010, the per diem rates as calculated per §967.A-C above shall be reduced by 4.6 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care and psychiatric costs as determined by the cost report or the Medicaid discharges or days as specified per §967.A-C for the period, multiplied by 90.63 percent of the target rate per discharge or per diem limitation as specified per §967.A-C for the period.

H. Effective for dates of service on or after January 1, 2011, the per diem rates as calculated per §967.A-C above shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care and psychiatric costs as determined by the cost report or the Medicaid discharges

or days as specified per §967.A-C for the period, multiplied by 88.82 percent of the target rate per discharge or per diem limitation as specified per §967.A-C for the period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, amended LR 36:2562 (November, 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#013

### **DECLARATION OF EMERGENCY**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

Inpatient Hospital Services  
Pre-Admission Certification  
(LAC 50:V.301)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50: V.301 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing repealed the December 20, 1985 Rule governing the reimbursement methodology and inpatient admission criteria for designated surgical procedures performed in an ambulatory (outpatient) setting, and amended the provisions of the June 20, 1994 Rule governing registration, length of stay assignments and pre-admission certification for inpatient hospital services to require pre-admission certification for all admissions to non-state and state operated acute care general hospitals (*Louisiana Register*, Volume 36, Number 1). The January 20, 2010 Rule also repromulgated the provisions contained in the June 20, 1994 Rule and a June 20, 2001 Rule governing pre-admission certification and length of stay assignments for inpatient psychiatric services for inclusion in the *Louisiana Administrative Code*.

The department determined that it was necessary to amend the provisions of the January 20, 2010 Rule to revise the provisions governing extensions of the initial length of stay assignment for inpatient hospital admissions (*Louisiana Register*, Volume 36, Number 2). This Emergency Rule is

being promulgated to continue the provisions of the January 26, 2010 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients who rely on the services provided by acute care hospitals.

Effective January 24, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing pre-admission certification for inpatient hospital services.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part V. Hospital Services**

#### **Subpart 1. Inpatient Hospitals**

### **Chapter 3. Pre-Admission Certification**

#### **§301. General Provisions**

A. - F.2. ...

a. Subsequent approved extensions may be submitted for consideration referencing customized data, Southern Regional and national length of stay data.

F.3. - J.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:66 (January 2010), amended LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#028

### **DECLARATION OF EMERGENCY**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

Laboratory and Radiology Services  
Reimbursement Rate Reduction  
(LAC 50:XIX.4329 and 4334-4337)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XIX.4329 and §§4334-4337 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this Schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency

Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for laboratory and radiology services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 11). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for laboratory and radiology services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule also repealed the provisions governing the reimbursement for outpatient hospital laboratory services from this Chapter as these provisions have been amended and repromulgated in LAC 50:V.Chapter 57. The department promulgated an Emergency Rule which amended the provisions of the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:XIX.4329 and §§4334-4337 as a result of the promulgation of the November 20, 2010 final Rule governing laboratory and radiology services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for laboratory and radiology services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$703,417 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for laboratory and radiology services to reduce the reimbursement rates.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XIX. Other Services**

#### **Subpart 3. Laboratory and Radiology**

### **Chapter 43. Billing and Reimbursement**

#### **Subchapter B. Reimbursement**

#### **§4329. Laboratory Services (Physicians and Independent Laboratories)**

A. - H. ...

I. Effective for dates of service on or after August 1, 2010, the reimbursement rates for laboratory services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

J. Effective for dates of service on or after January 1, 2011, the reimbursement rates for laboratory services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 28:1025 (May 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:

#### **§4334. Radiology Services**

A. - G. ...

H. Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

I. Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:

#### **§4335. Portable Radiology Services**

A. - E. ...

F. Effective for dates of service on or after August 1, 2010, the reimbursement rates for portable radiology services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rates for portable radiology services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 30:1026 (May 2004), amended LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:

#### **§4337. Radiation Therapy Centers**

A. - E. ...

F. Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box

91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#014

### **DECLARATION OF EMERGENCY**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

Medical Transportation Program  
Emergency Ambulance Services  
Reimbursement Rate Reduction  
(LAC 50:XXVII.325 and 353)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXVII.325 and §353 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for emergency medical transportation services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 11).

Due to a budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for emergency medical transportation services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$253,371 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for emergency medical transportation services to reduce the reimbursement rates.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part XXVII. Medical Transportation Program**  
**Chapter 3. Emergency Medical Transportation**  
**Subchapter B. Ground Transportation**

**§325. Reimbursement**

A. - G. ...

H. Effective for dates of service on or after January 1, 2011, the reimbursement rates for emergency ambulance transportation services shall be reduced by 2 percent of the rate on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:878 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1248 (June 2010), amended LR 36:2564 (November 2010), LR 37:

**Subchapter C. Aircraft Transportation**

**§353. Reimbursement**

A. - E. ...

F. Effective for dates of service on or after January 1, 2011, the reimbursement rates for fixed winged and rotor winged emergency air ambulance services shall be reduced by 2 percent of the rate on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:70 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2594 (November 2010), amended LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#010

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals**  
**Bureau of Health Services Financing**

Medical Transportation Program  
Non-Emergency Ambulance Services  
Reimbursement Rate Reduction  
(LAC 50:XXVII.571)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXVII.571 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the

Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for non-emergency ambulance transportation services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 11).

Due to a budgetary shortfall in state fiscal year 2011, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for non-emergency ambulance transportation services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$97,865 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for non-emergency ambulance services to reduce the reimbursement rates.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part. XXVII. Medical Transportation Program**  
**Chapter 5. Non-Emergency Medical Transportation**  
**Subchapter D. Reimbursement**

**§571. Non-Emergency Ambulance Transportation**

A. - D. ...

E. Effective for dates of service on or after January 1, 2011, the reimbursement rates for non-emergency ambulance transportation services shall be reduced by 2 percent of the rates in effect on December 30, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:462 (March 2007), LR 34:878 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2564 (November 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#003

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Medical Transportation Program  
Non-Emergency Medical Transportation  
Reimbursement Rate Reduction  
(LAC 50:XXVII.573)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXVII.573 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2011, the Department of Health and Hospitals, Bureau of Health of Health Services Financing amended the provisions governing the reimbursement methodology for non-emergency medical transportation services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 11). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for non-emergency medical transportation services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule was amended to revise the formatting of LAC 50:XXVII.573 as a result of the promulgation of the November 20, 2010 final Rule governing non-emergency medical transportation services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for non-emergency medical transportation services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medical Transportation Program by approximately \$73,150 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for non-emergency medical transportation services to reduce the reimbursement rates.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part XXVII. Medical Transportation Program

#### Chapter 5. Non-Emergency Medical Transportation

#### Subchapter D. Reimbursement

#### §573. Non-Emergency, Non-Ambulance Transportation

A. - C. ...

D. Effective for dates of service on or after August 1, 2010, the reimbursement rates for non-emergency, non-ambulance medical transportation services shall be reduced by 4.5 percent of the rates in effect on July 31, 2010.

1. Friends and family providers are excluded from the rate reduction.

E. Effective for dates of service on or after January 1, 2011, the reimbursement rates for non-emergency, non-ambulance medical transportation services shall be reduced by 2 percent of the rates in effect on December 31, 2010.

1. Friends and family providers are excluded from the rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:879 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#002

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Mental Health Rehabilitation Program  
Reimbursement Rate Reduction  
(LAC 50:XV.901)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.901 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is

directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for the Mental Health Rehabilitation (MHR) Program to reduce the reimbursement rates paid for mental health rehabilitation services (*Louisiana Register*, Volume 36, Number 11). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which terminated the coverage of Parent/Family Intervention (Intensive) (PFII) services in the MHR Program and amended the provisions governing medical necessity for MHR services in order to establish continued treatment criteria (*Louisiana Register*, Volume 36, Number 8). Recipients receiving PFII services shall be transitioned to comparable services available in the MHR Program. The department promulgated an Emergency Rule which amended the provisions of the August 1, 2010 Emergency Rule to revise the formatting of LAC 50:XV.901 as a result of the promulgation of the November 20, 2010 final Rule governing mental health rehabilitation services.

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for mental health rehabilitation services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$618,390 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for mental health rehabilitation services.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XV. Services for Special Populations**

##### **Subpart 1. Mental Health Rehabilitation**

#### **Chapter 9. Reimbursement**

##### **§901. Reimbursement Methodology**

A. - F. ...

G. Effective for dates of service on or after August 1, 2010, Medicaid reimbursement shall be terminated for parent/family intervention (intensive) services.

H. Effective for dates of service on or after January 1, 2011, the reimbursement rates for Mental Health Rehabilitation services shall be reduced by 3.3 percent of the rates on file as of December 31, 2010.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1091 (May 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1899 (September 2009), amended LR 36:1249 (June 2010), LR 36:2564 (November 2010), LR:37

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#016

### **DECLARATION OF EMERGENCY**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

Multi-Systemic Therapy  
Reimbursement Rate Reduction  
(LAC 50:XV.25701)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.25701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: “The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law.” This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing multi-systemic therapy (MST) to reduce the reimbursement rates and to establish prior authorization requirements (*Louisiana Register*, Volume 36, Number 11). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement

methodology for MST services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule was amended to revise the formatting of LAC 50:XV.25701 as a result of the promulgation of the November 20, 2010 final Rule governing MST services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has now determined that it is necessary to further reduce the reimbursement rates paid for MST services. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$254,156 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for multi-systemic therapy services to reduce the reimbursement rates.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XV. Services for Special Populations**

##### **Subpart 17. Multi-Systemic Therapy**

#### **Chapter 257. Reimbursement**

##### **§25701. Reimbursement Methodology**

A. - C. ...

D. Effective for dates of service on or after August 1, 2010, the reimbursement rates for multi-systemic therapy services shall be reduced by 2.63 percent of the rates on file as of July 31, 2010.

E. Effective for dates of service on or after January 1, 2011, the reimbursement rates for multi-systemic therapy services shall be reduced by 3 percent of the rates on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services financing, LR 35:247 (February 2009), amended LR 36:1250 (June 2010), LR 36:2565 (November 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#017

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Bureau of Health Services Financing**

Nursing Facilities—Reimbursement Methodology  
Minimum Data Set Assessments  
(LAC 50:VII.1301, 1307, 1313 and 1315)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1301, §1307, §1313 and §1315 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

In compliance with Act 694 of the 2001 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repealed the provisions governing the prospective reimbursement methodology for private nursing facilities and established a new reimbursement methodology based on a case-mix price-based reimbursement system for private and public nursing facilities (*Louisiana Register*, Volume 28, Number 6). The department amended the June 20, 2002 Rule to incorporate new definitions and revised current definitions governing nursing facility reimbursements. The December 20, 2002 Rule also revised the provisions governing the submission of cost reports and adopted provisions governing verification of minimum data set (MDS) assessments and the appeal process for dispute of MDS review findings (*Louisiana Register*, Volume 28, Number 12).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to revise the provisions governing MDS assessments in order to comply with new federal requirements (*Louisiana Register*, Volume 36, Number 10). The October 20, 2010 Emergency Rule also changed the date that MDS assessments are due. This Emergency Rule is being promulgated to continue the provisions of the October 20, 2010 Emergency Rule. This action is being taken to avoid sanctions from the Centers for Medicare and Medicaid Services for noncompliance with the federal mandate to utilize the new MDS assessment data.

Effective February 18, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to revise the provisions governing MDS assessments.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part VII. Long Term Care Services**  
**Subpart 1. Nursing Facilities**  
**Chapter 13. Reimbursement**  
**§1301. Definitions**

\* \* \*

*Assessment Reference Date*—the date on the Minimum Data Set (MDS) used to determine the due date and delinquency of assessments. This date is used in the case-mix reimbursement system to determine the last assessment for each resident present in the facility and is included in the quarterly case-mix report.

\* \* \*

*Case-Mix Index*—a numerical value that describes the resident's relative resource use within the groups under the Resource Utilization Group (RUG-III) classification system, or its successor, prescribed by the department based on the resident's MDS assessments. Two average CMIs will be determined for each facility on a quarterly basis, one using all residents (the facility average CMI) and one using only Medicaid residents (the Medicaid average CMI).

*Case-Mix MDS Documentation Review (CMDR)*—a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

\* \* \*

*Delinquent MDS Resident Assessment*—an MDS assessment that is more than 121 days old, as measured by the Assessment Reference Date (ARD) field on the MDS.

\* \* \*

*Facility Cost Report Period Case-Mix Index*—the average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

Example: A January 1, 2011-December 31, 2011 cost report period would use the facility-wide average case-mix indices calculated for March 31, 2011, June 30, 2011, September 30, 2011 and December 31, 2011.

1. Repealed.

*Facility-Wide Average Case-Mix Index*—the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter. If a facility does not have any residents as of the last day of a calendar quarter or the average resident case-mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case-mix index using occupied and valid statewide facility case-mix indices may be used.

*Final Case-Mix Index Report (FCIR)*—the final report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter, referred to as the point-in-time.

\* \* \*

*Minimum Data Set (MDS)*—a core set of screening and assessment data, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the current MDS assessment required and approved by the Centers for Medicare and Medicaid Services (CMS).

*MDS Supportive Documentation Guidelines*—the department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III or its successor classification system. These guidelines shall be maintained by the department and updated and published as necessary.

On-Site MDS Review—Repealed.

\* \* \*

*Point-in-Time*—Repealed.

*Preliminary Case Mix Index Report (PCIR)*—the preliminary report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter.

\* \* \*

*RUG-III Resident Classification System*—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

*Summary Review Results Letter*—a letter sent to the nursing facility that reports the final results of the case-mix MDS documentation review and concludes the review.

1. The Summary Review Results letter will be sent to the nursing facility within 10 business days after the final exit conference date.

\* \* \*

*Unsupported MDS Resident Assessment*—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supporting documentation guidelines and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**§1307. Case-Mix Index Calculation**

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34-group, or its successor, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.20, or its successor, case-mix indices developed by CMS shall be the basis for calculating average

case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group, or its successor, will be excluded from the average case-mix index calculation.

B. Effective with the January 1, 2011 rate setting, each resident in the facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor, on the last day of each calendar quarter. The RUG-III group, or its successor, is calculated based on the resident's most current assessment, available on the last day of each calendar quarter, and shall be translated to the appropriate case-mix index. From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

C. Effective with the January 1, 2011 rate setting, the facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1792 (August 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§1313. Case-Mix Minimum Data Set Documentation Reviews and Case-Mix Index Reports**

A. The department or its contractor shall provide each nursing facility with the Preliminary Case-Mix Index Report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. The PCIR will serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction policy where applicable. The department or its contractor shall provide each nursing facility with a Final Case-Mix Index Report (FCIR) (point-in-time) utilizing MDS assessments after allowing the facilities a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department or its contractor determines that a nursing facility has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case-mix index associated with the RUG-III group "BC1-Delinquent" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, classification system.

B. The department or its contractor shall periodically review the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify facilities of the Case-Mix MDS Documentation Reviews (CMDR) not less than two business days prior to the start of the review date and a FAX, electronic mail or other form of communication will be provided to the administrator and MDS coordinator on the same date identifying possible

documentation that will be required to be available at the start of the on-site CMDR.

1. The department or its contractor shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the facility or 10 assessments and shall include those transmitted assessments posted on the most current FCIR. The CMDR will determine the percentage of assessments in the sample that are unsupported MDS resident assessments. The department may review additional or alternative MDS assessments, if it is deemed necessary.

2. When conducting the CMDR, the department or its contractor shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the RN reviewers prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered for the CMDR.

3. Upon request by the department or its contractor, the nursing facility shall be required to produce a computer-generated copy of the transmitted MDS assessment which shall be the basis for the CMDR.

4. After the close of the CMDR, the department or its contractor will submit its findings in a Summary Review Results (SRR) letter to the facility within 10 business days following the exit conference.

5. The following corrective action will apply to those facilities with unsupported MDS resident assessments identified during an on-site CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 25 percent, the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

b. If the percentage of unsupported MDS assessments in the total sample is equal to or less than the threshold percentage as shown in column (B) of the table in Subparagraph e below, no corrective action will be applied.

c. If the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the table in Subparagraph e below, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The facility's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. A follow-up CMDR process described in Subparagraphs d and e may be utilized at the discretion of the department.

d. Those providers exceeding the thresholds (see column (B) of the table in Subparagraph e during the initial on-site CMDR will be given 90 days to correct their assessing and documentation processes. A follow-up CMDR may be performed at the discretion of the department at least 30 days after the facility's 90-day correction period. The department or its contractor shall notify the facility not less than two business days prior to the start of the CMDR date. A FAX, electronic mail, or other form of communication will be provided to the administrator and MDS coordinator on the same date identifying documentation that must be available at the start of the on-site CMDR.

e. After the follow-up CMDR, if the percentage of unsupported MDS assessments in the total sample is greater

than the threshold percentage as shown in column (B) of the following table, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The facility's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. In addition, facilities found to have unsupported MDS resident assessments in excess of the threshold in Column (B) of the table below may be required to enter into an MDS Documentation Improvement Plan with the Department of Health and Hospitals. Additional follow-up CMDR may be conducted at the discretion of the department.

Effective Date (A)	Threshold Percent (B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006 and beyond	25%

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**§1315. Appeal Process**

A. If the facility disagrees with the CMDR findings, a written request for an informal reconsideration must be submitted to the department or its contractor within 15 business days of the facility's receipt of the CMDR findings in the SRR letter. Otherwise, the results of the CMDR findings are considered final and not subject to appeal. The department or its contractor will review the facility's informal reconsideration request within 10 business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility. No appeal of findings will be accepted until after communication of final results of the informal reconsideration process.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2538 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A

copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#080

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Nursing Facilities—Reimbursement Rate Reduction  
(LAC 50:VII.1305)**

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a continuing budgetary shortfall in state fiscal year 2010, the department amended the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem rate paid to non-state nursing facilities (*Louisiana Register*, Volume 36, Number 11). In anticipation of projected expenditures in the Medical Vendor Program exceeding the funding allocated in the General Appropriations Act for state fiscal year (SFY) 2011, the department promulgated an Emergency Rule which further reduced the per diem rates paid to non-state nursing facilities (*Louisiana Register*, Volume 36, Number 7). The department amended the provisions of the July 1, 2010 Emergency Rule to revise the formatting of LAC 50:VII.1305 as a result of the promulgation of the July 20, 2010 and the August 20, 2010 final Rules governing the reimbursement methodology for nursing facilities (*Louisiana Register*, Volume 36, Number 10).

The department now proposes to amend the provisions of the October 20, 2010 Emergency Rule governing the SFY 2011 rate reduction to revise the formatting of LAC 50:VII.1305 as a result of the promulgation of the November 20, 2010 final Rule. This action is being taken to ensure that these provisions are appropriately incorporated into the *Louisiana Administrative Code*.

Effective January 20, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the October 1, 2010 Emergency Rule governing the reimbursement methodology for non-state nursing facilities.

**Title 50  
PUBLIC HEALTH—MEDICAL ASSISTANCE  
Part VII. Long Term Care Services  
Subpart 1. Nursing Facilities  
Chapter 13. Reimbursement  
§1305. Rate Determination**

A. - F. ...

G. Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 until such time as the rate is rebased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#081

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services  
Non-Rural, Non-State Hospitals and  
Children's Specialty Hospitals  
Reimbursement Rate Reduction  
(LAC:V.5313, 5317, 5513, 5517,  
5713, 5719, 6115 and 6119)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.5313, §5317, §5513, §5517, §5713, §5719, §6115 and §6119 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for outpatient hospital services to reduce the reimbursement rates paid to

non-rural, non-state hospitals and children's specialty hospitals (*Louisiana Register*, Volume 36, Number 9). As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing outpatient hospital services to reduce the reimbursement rates paid to non-rural, non-state hospitals and children's specialty hospitals (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule was amended to revise the formatting as a result of the promulgation of the September 20, 2010 final Rule governing outpatient hospital services (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for outpatient hospital services to further reduce the reimbursement rates paid to non-rural, non-state hospitals and children's specialty hospitals. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures for outpatient hospital services by approximately \$1,308,661 for state fiscal year 2010-2011.

Taking the proposed rate reductions into consideration, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private (non-state) outpatient hospital services and children's specialty hospital services under the State Plan are available at least to the extent that they are available to the general population in the state.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for outpatient hospital services to reduce the reimbursement rates.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospitals

##### Subpart 5. Outpatient Hospitals

#### Chapter 53. Outpatient Surgery

##### Subchapter B. Reimbursement Methodology

#### §5313. Non-Rural, Non-State Hospitals

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:

## **§5317. Children's Specialty Hospitals**

A. - B.1. ...

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Final reimbursement shall be 86.15 percent of allowable cost as calculated through the cost report settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:

## **Chapter 55. Clinic Services**

### **Subchapter B. Reimbursement Methodology**

#### **§5513. Non-Rural, Non-State Hospitals**

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:

## **§5517. Children's Specialty Hospitals**

A. - B. ...

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:

## **Chapter 57. Laboratory Services**

### **Subchapter B. Reimbursement Methodology**

#### **§5713. Non-Rural, Non-State Hospitals**

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:

## **§5719. Children's Specialty Hospitals**

A. - B. ...

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), amended LR 37:

## **Chapter 61. Other Outpatient Hospital Services**

### **Subchapter B. Reimbursement Methodology**

#### **§6115. Non-Rural, Non-State Hospitals**

A. - D. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 4.6 percent of the rates effective as of July 31, 2010. Final reimbursement shall be at 71.13 percent of allowable cost through the cost settlement process.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state

hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 2 percent of the rates effective as of December 31, 2010. Final reimbursement shall be at 69.71 percent of allowable cost through the cost settlement process.

1. Small rural hospitals as defined in R.S. 40:1300.143 shall be exempted from this rate reduction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), amended LR 36:1250 (June 2010), amended LR 36:2043 (September 2010), LR 37:

#### **§6119. Children's Specialty Hospitals**

A. - B.1. ...

C. Effective for dates of service on or after August 1, 2010, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 4.6 percent of the rates effective as of July 31, 2010.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

D. Effective for dates of service on or after January 1, 2011, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 2 percent of the rates effective as of December 31, 2010.

1. Final reimbursement shall be 86.15 percent of allowable cost as calculated through the cost report settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2044 (September 2010), amended LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#005

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Bureau of Health Services Financing**

Personal Care Services—Long-Term  
Reimbursement Rate Reduction  
(LAC 50:XV.12917)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XV.12917 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first. As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the reimbursement methodology for long-term personal care services to reduce the reimbursement rates (*Louisiana Register*; Volume 36, Number 6).

As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for long-term personal care services to reduce the reimbursement rates (*Louisiana Register*, Volume 36, Number 8).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to amend the provisions governing the reimbursement methodology for long-term personal care services to further reduce the reimbursement rates. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$2,494,360 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions governing the reimbursement methodology for long-term personal care services to reduce the reimbursement rates.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part XV. Services for Special Populations**  
**Subpart 9. Personal Care Services**

**Chapter 129. Long-Term Care**

**§12917. Reimbursement Methodology**

A. - E. ...

F. Effective for dates of service on or after August 1, 2010, the reimbursement rate for long-term personal care services shall be reduced by 4.6 percent of the rate on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rate for long-term personal care services shall be reduced by 5.8 percent of the rate on file as of December 31, 2010.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#015

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals**  
**Bureau of Health Services Financing**

Pharmacy Benefits Management Program  
Maximum Allowable Costs (LAC 50:XXIX.949)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXIX.949 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repromulgated all of the Rules governing the Pharmacy Benefits Management Program in a codified format in Title 50 of the *Louisiana Administrative Code* (*Louisiana*

*Register*, Volume 32, Number 6). The department later promulgated a Rule (*Louisiana Register*, Volume 34, Number 1) amending the provisions of the June 20, 2006 Rule governing methods of payments in order to comply with the directives of Act 801 of the 2006 Regular Session of the Louisiana Legislature, which directed the department to submit a Medicaid State Plan amendment to the Centers for Medicare and Medicaid Services (CMS) to increase the Medicaid dispensing fee on prescription drugs, contingent upon CMS' approval of the proposed amendment. CMS subsequently disapproved the proposed amendment to the Medicaid State Plan that had been submitted in compliance with Act 801. An Emergency Rule was later promulgated to repeal the January 20, 2008 Rule and to restore the repealed provisions of the June 20, 2006 Rule in the *Louisiana Administrative Code* (*Louisiana Register*, Volume 36, Number 1).

Act 10 of the 2009 Regular Session of the Louisiana Legislature provided that the department may redefine the reimbursement methodology for multiple source drugs in establishing the state maximum allowable cost (MAC) in order to control expenditures to the level of appropriations for the Medicaid Program. In accordance with the provisions of Act 10, the department promulgated an Emergency Rule to redefine the Louisiana maximum allowable cost (LMAC) (*Louisiana Register*, Volume 36, Number 1). In addition, the dispensing fee was increased for drugs with an LMAC.

The department subsequently determined that it was necessary to repeal the January 1, 2010 Emergency Rule in its entirety and amend the provisions governing the methods of payment for prescription drugs to redefine the LMAC (*Louisiana Register*, Volume 36, Number 2). The department promulgated an Emergency Rule to amend the February 1, 2010 Emergency Rule to revise the provisions governing the methods of payment for prescription drugs to further redefine the LMAC and increase the dispensing fee (*Louisiana Register*, Volume 36, Number 3). The department determined that it was necessary to repeal the March 1, 2010 Emergency Rule in its entirety and promulgated an Emergency Rule to amend the provisions governing the methods of payment for prescription drugs to revise the LMAC provisions (*Louisiana Register*, Volume 36, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2010 Emergency Rule. This action is being taken to control expenditures in the Medical Assistance Program and to avoid a budget deficit.

Effective February 15, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the methods of payment for prescriptions covered under the Pharmacy Benefits Management Program.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part XXIX. Pharmacy**

**Chapter 9. Methods of Payment**

**Subchapter D. Maximum Allowable Costs**

**§949. Cost Limits**

A. - B. ...

1. Louisiana Maximum Allowable Cost (LMAC) is the average actual acquisition cost of a drug, defined as the pharmacist's payment made to purchase a drug product, adjusted by a multiplier of 2.35.

2. LMAC reimbursement will apply to certain multiple source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Louisiana Medicaid Agency. Drugs are subject to LMAC if there are at least two non-innovator multiple source alternative products available that are classified by the FDA as Category "A" in the Approved Drug Products with Therapeutic Equivalence Evaluations.

3. LMAC rates are based on the average actual acquisition cost per drug, adjusted by a multiplier of 2.35, which assures that each rate is sufficient to allow reasonable access by providers to the drug at or below the established LMAC rate. The LMAC rate will apply to all versions of a drug that share the same active ingredient combination, strength, dosage form, and route of administration.

4. Average actual acquisition cost will be determined through a semi-annual collection and review of pharmacy invoices and other information deemed necessary by the Louisiana Medicaid Agency and in accordance with applicable State and Federal law.

5. In addition to the semi-annual review, the Louisiana Medicaid Agency will evaluate on an ongoing basis throughout the year and adjust the rates as necessary to reflect prevailing market conditions and to assure that pharmacies have reasonable access to drugs at or below the applicable LMAC rate. Providers shall be given advance notice of any additions, deletions, or adjustments in price. A complete LMAC rate listing will be available to providers and updated periodically.

6. In no case shall a recipient be required to provide payment for any difference in a prescription price that may occur with implementation of the LMAC limit, nor may BHSF use a cost which exceeds the established maximums except for physician certification for brand name drugs.

C. - E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#079

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Pregnant Women Extended Services  
Dental Services  
Reimbursement Rate Reduction  
(LAC 50:XV.16107)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.16107 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature which states: "The secretary is directed to utilize various cost containment measures to ensure expenditures in the Medicaid Program do not exceed the level appropriated in this schedule, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations, drug therapy management, disease management, cost sharing, and other measures as permitted under federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2010, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for dental services to reduce the reimbursement rates for services rendered to Medicaid eligible pregnant women (*Louisiana Register*, Volume 36, Number 9).

As a result of a budgetary shortfall in state fiscal year 2011, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for dental services to reduce the reimbursement rates for services rendered to Medicaid eligible pregnant women (*Louisiana Register*, Volume 36, Number 8). The August 1, 2010 Emergency Rule was amended to revise the formatting of LAC 50:XV.16107 as a result of the promulgation of the September 20, 2010 final Rule governing the Pregnant Women Extended Services Dental Program (*Louisiana Register*, Volume 36, Number 11).

Due to a continuing budgetary shortfall, the department has determined that it is necessary to further reduce the reimbursement rates for dental services rendered to Medicaid eligible pregnant women. This action is being taken to avoid a budget deficit in the medical assistance programs. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$29,925 for state fiscal year 2010-2011.

Effective January 1, 2011, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for dental services rendered to Medicaid eligible pregnant women.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XV. Services for Special Populations**

#### **Subpart 13. Pregnant Women Extended Services**

#### **Chapter 161. Dental Services**

#### **§16107. Reimbursement**

A. - D.3.q. ...

E. Effective for dates of service on or after August 1, 2010, the reimbursement fees for dental services provided to Medicaid eligible pregnant women shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 69 percent for the comprehensive periodontal evaluation exam;

2. 65 percent for the following diagnostic services:

- a. intraoral-periapical first film;
- b. intraoral-periapical, each additional film; and
- c. panoramic film and prophylaxis, adult; and

3. 58 percent for the remaining diagnostic services and all periodontic procedures, restorative and oral and maxillofacial surgery procedures which includes the following dental services:

- a. intraoral, occlusal film;
- b. bitewings, two films;
- c. amalgam (one, two or three surfaces) primary or permanent;
- d. amalgam (four or more surfaces);
- e. resin-based composite (one, two or three surfaces), anterior;
- f. resin-based composite (four or more surfaces) or involving incisal angle, anterior;
- g. resin-based composite crown, anterior;
- h. resin-based composite (one, two, three, four or more surfaces), posterior;
- i. prefabricated stainless steel crown, primary or permanent tooth;
- j. prefabricated resin crown;
- k. periodontal scaling and root planning (four or more teeth per quadrant);
- l. full mouth debridement to enable comprehensive evaluation and diagnosis;
- m. extraction, coronal remnants-deciduous tooth;
- n. extraction, erupted tooth or exposed root (elevation and/or forceps removal);
- o. surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
- p. removal of impacted tooth, soft tissue; and
- q. removal of impacted tooth, partially bony.

F. Effective for dates of service on or after January 1, 2011, the reimbursement fees for dental services provided to Medicaid eligible pregnant women shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report seventieth percentile, unless otherwise stated in this Chapter:

1. 67.5 percent for the comprehensive periodontal evaluation exam;

2. 63.5 percent for the following diagnostic services:

- a. intraoral-periapical first film;
- b. intraoral-periapical, each additional film; and
- c. panoramic film and prophylaxis, adult; and

3. 57 percent for the remaining diagnostic services and all periodontic procedures, restorative and oral and maxillofacial surgery procedures which includes the following dental services:

- a. intraoral, occlusal film;
- b. bitewings, two films;
- c. amalgam (one, two or three surfaces) primary or permanent;
- d. amalgam (four or more surfaces);
- e. resin-based composite (one, two or three surfaces), anterior;
- f. resin-based composite (four or more surfaces) or involving incisal angle, anterior;
- g. resin-based composite crown, anterior;
- h. resin-based composite (one, two, three, four or more surfaces), posterior;
- i. prefabricated stainless steel crown, primary or permanent tooth;
- j. prefabricated resin crown;
- k. periodontal scaling and root planning (four or more teeth per quadrant);
- l. full mouth debridement to enable comprehensive evaluation and diagnosis;
- m. extraction, coronal remnants-deciduous tooth;
- n. extraction, erupted tooth or exposed root (elevation and/or forceps removal);
- o. surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
- p. removal of impacted tooth, soft tissue; and
- q. removal of impacted tooth, partially bony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:434 (March 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1902 (September 2009), amended LR 36:2044 (September 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein  
Secretary

1101#007

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Office of Public Health

Added Controlled Dangerous Substances  
(LAC 48:I.3943)

The Department of Health and Hospitals, Office of Public Health (DHH/OPH), pursuant to the emergency rulemaking authority granted by R.S. 40:962, hereby adopts the following Emergency Rule for the protection of public health. The secretary has determined that this Emergency Rule is necessary to avoid an imminent peril to the public health, safety, or welfare. This Emergency Rule is promulgated specifically in accordance with R.S. 49:953 of the Administrative Procedure Act (R.S. 49:950, et seq.).

The DHH/OPH finds it necessary to make changes to the Louisiana Administrative Code based on the criteria and guidance set forth in Louisiana Revised Statute 40:962 and 40:963. In reaching the decision to add the substances listed herein to Schedule I, the secretary has considered the factors as directed by Louisiana Revised Statute 40:962(C). The secretary has determined that Schedule I is the most appropriate due to his findings that the substances added herein have a high potential for abuse, the substances have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the substances under medical supervision. Accordingly, the following Emergency Rule, effective January 6, 2011, shall remain in effect for a maximum of 120 days, or until the final Rule is promulgated, whichever occurs first.

#### Title 48

### PUBLIC HEALTH—GENERAL

#### Part I. General Administration

##### Subpart 1. General

#### Chapter 39. Controlled Dangerous Substances

##### §3943. Added Controlled Dangerous Substances

A. - C.1. ...

D. The following drugs or substances are added to Schedule I of the Louisiana Uniform Controlled Dangerous Substances Law, R.S. 40:961 et seq.:

1. 3,4-Methylenedioxymethcathinone (Methylone);
2. 3,4-Methylenedioxypyrovalerone (MDPV);
3. 4-Methylmethcathinone (Mephedrone);
4. 4-Methoxymethcathinone;
5. 3-Fluoromethcathinone;
6. 4-Fluoromethcathinone.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:961-1036.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Health Standards Section, LR 18:962 (September 1992), repromulgated LR 18:1132 (October 1992), amended by Department of Health and Hospitals, Office of Public Health, LR 37:

Bruce D. Greenstein  
Secretary

1101#031

## DECLARATION OF EMERGENCY

### Department of Public Safety and Corrections Corrections Services

Judicial Agency Referral Residential Facilities  
(LAC 22:I.Chapter 13)

In accordance with the provisions of R.S. 49:953, the Department of Public Safety and Corrections, Corrections Services, hereby determines that adoption of an emergency rule for the Judicial Agency Referral Residential Facilities mandated by Act No. 496 of the 2010 Regular Session is necessary and failure to adopt the rule on an emergency basis will result in imminent peril to the public health, safety and welfare. The Department of Public Safety and Corrections, Corrections Services, has determined that the adoption of an emergency rule for implementation of the Judicial Agency Referral Residential Facilities is necessary and hereby provides notice of its declaration of emergency effective on January 5, 2011, in accordance with R.S. 49:953. This Emergency Rule shall be in effect for 120 days or until adoption of the final rule, whichever occurs first.

#### Title 22

### CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

#### Part I. Corrections

#### Chapter 13. Residential Referral

##### Subchapter A. General Provisions

##### §1301. Judicial Agency Referral Residential Facilities

A. Purpose—to state the secretary's rules relative to the housing or temporary residence of individuals who have been arrested for the commission of a crime and are referred by any judicial agency to a certified residential facility and to provide for the construction, standards of operation and services provided by such residential facilities.

B. Applicability—deputy secretary, undersecretary, chief of operations, assistant secretary, Director of Probation and Parole and administrators of housing or temporary residential facilities. The chief of operations is responsible for the overall implementation, compliance and review of this regulation. Each unit head is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation.

C. Policy. No facility not otherwise required to be licensed by the Department of Health and Hospitals or Department of Children and Family Services, shall provide housing or temporary residence to any individual referred by a judicial agency except in accordance with this regulation. Referrals to such facilities by a judicial agency may only be made after the facility has been inspected by the Department of Public Safety and Corrections and certified to be in compliance with the standard operating procedures established pursuant to this regulation.

#### D. Procedure

1. The facility shall comply with all building codes, local zoning requirements and ordinances with regard to permits and licenses.

2. The state fire marshal and state health officer shall determine rated bed capacity and approval for occupancy.

3. The facility shall comply with the standard operating procedures (SOP) for judicial agency referral residential facilities. Revisions to the SOP shall be accomplished through this regulation under the signature of the secretary.

4. The facility shall be accredited by the American Correctional Association within twenty-four months of opening and shall maintain accreditation at all times thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:667 (April 2007), amended LR 37:

### **Subchapter B. Standard Operating Procedures for Judicial Agency Referral Residential Facilities**

#### **§1303. Standard Operating Procedures**

##### **A. American Correctional Association (ACA)**

1. All judicial agency referral residential facilities shall be operated in accordance with R.S. 40:2852 and must maintain accreditation by the American Correctional Association Standards for Adult Community Residential Services. Facilities shall be accredited by the American Correctional Association (ACA) within twenty-four months of opening as a judicial agency referral residential facility.

2. Written policies and procedures that reflect compliance with ACA and the standard operating procedures for judicial agency referral residential facilities, as well as facility rules for resident behavior must be submitted to and approved by the secretary of the Department of Public Safety and Corrections prior to beginning operations or implementation. Any proposed revisions to policies, procedures or facility rules must be submitted for approval prior to implementation.

##### **B. Administration**

1. The facility shall have a written document describing the facility's organization. The description shall include an organizational chart that groups similar functions, services and activities in administrative subunits. The chart is reviewed at least annually and updated, if needed.

2. Regular meetings between the facility administrator and all department heads shall be held monthly and there is formal documentation that such meetings occurred.

3. Written policy, procedure and practice shall provide for an independent financial audit of the facility at least annually or as stipulated by statute or regulation, but at least every three years.

4. Each facility shall have insurance coverage that includes, at a minimum, property insurance and comprehensive general liability insurance. Such insurance is provided either through private companies or self insurance.

5. Residents' personal funds held by the facility are controlled by accounting procedures and in accordance with Subsection K, Resident's Personal Funds.

6. Staffing requirements for the facility shall ensure there is 24 hour on site staff monitoring and coordinating of the facility's life safety and communications systems and also to respond to resident needs.

7. Standard of Conduct for Employees of Judicial Agency Referral Residential Programs:

a. Employees are expected to conduct themselves in a manner that will not bring discredit upon their facility;

b. Each employee shall be advised of the location of the facility manual that specifies the operating and maintenance requirements of the facility. The location of the manual shall be accessible to all employees.

c. The facility shall provide adequate staff at the facility 24 hours a day to control the movement and location at all times of all residents assigned to the facility and to respond to their needs. However, when both female and male residents are housed in the same facility, at least one male and one female staff member are on duty at all times.

d. There shall be a method of staff identification so that they can be readily identified by visitors through utilization of name tags, identification cards, etc.

e. There shall be written job descriptions and job qualifications for all positions in the facility. Each job description includes at a minimum: job title; responsibilities of the position; required minimum experience; and education.

f. All full-time employees must receive 40 hours of orientation training prior to undertaking their assignments (administrators, managers, professional and careworkers) and must participate in 40 hours of training their first year of employment and each year thereafter. Clerical/support staff shall be provided with 16 hours of training in addition to orientation during their first year and 16 hours of training each year thereafter. All training curriculum shall be in accordance with the applicable ACA standards.

8. A training procedure shall be in place which shall include orientation for all new employees (appropriate to their job) prior to assuming a position.

9. Case records shall be maintained for each resident housed at the facility.

10.a. Written records or logs shall be maintained at the facility which continuously documents the following information:

- i. personnel on duty;
- ii. resident population;
- iii. admission and release of residents;
- iv. shift activities;
- v. entry/exit of all visitors including legal/medical;
- vi. unusual occurrences (including but not limited to major and minor disturbances, fires, escapes, deaths, serious illness or injury and assaults or other acts of violence.)

b. Shift reports are also prepared after the completion of each shift.

##### **C. Physical Plant**

1. The facility shall comply with the requirements of the state fire marshal and shall have a specific plan for addressing deficiencies, if any, that is approved by the state fire marshal. The state fire marshal shall approve any variances, exception or equivalencies.

2. The facility shall comply with the requirements of the state health officer and shall have a specific plan for addressing deficiencies, if any, that is approved by the state health officer.

3. The number of residents present at the facility shall not exceed the rated bed capacity as determined by the state fire marshal and state health officer. The state fire marshal shall determine a capacity based upon exiting capabilities. The state health officer shall determine a capacity based

upon the ratio of plumbing fixtures to residents and square footage. The rated capacity shall be the lower of these two figures.

4. Residents shall have access to toilets and hand washing facilities 24 hours per day and shall have access to operable showers on a reasonable schedule.

5. The facility shall have sanitary areas for the storage of all foods that comply with applicable state and/or federal guidelines.

6. The facility shall have a method to ensure the control of vermin and pests.

7. Toilet and hand basin facilities are available to food service personnel in proximity to the food preparation area.

8. The facility shall have exits that are properly positioned, clear, distinct and permanently marked to ensure the timely evacuation of residents and staff in the event of fire or other emergency.

9. The facility shall comply with all building codes, local zoning requirements and ordinances with regard to permits and licenses.

10. The facility shall have a written emergency plan, which includes an evacuation plan, to be used in the event of a fire or major emergency. Evacuation drills shall be conducted at least quarterly on each shift when the majority of the residents are present. Facility staff shall be trained in the implementation of written emergency plans and the plans shall be disseminated to appropriate local authorities, including the Department of Public Safety and Corrections.

11. A qualified person conducts fire inspections at least quarterly and equipment is tested as specified by the manufacturer or the fire authority, whichever is more frequent. All furnishings shall comply with fire safety performance requirements.

12. All flammable materials shall be handled and stored safely. The use of toxic and caustic materials shall be controlled.

#### D. Facility Operations

1. The facility shall have a system for physically counting residents that includes strict accountability for residents assigned to the program. This shall include residents who are absent from the program for work, education or other temporary absence.

2. A current master list shall be maintained at all times of all residents assigned to the facility. This list is to be updated immediately whenever the facility receives, releases or removes a resident from the facility.

3. There are several forms of control that must be considered around the facility. Physical control of the residents assures that all are accounted for at all times. When a count is conducted and it is found that a resident who is not physically present in the facility has not signed out on the log in accordance with the appropriate procedure or has signed out but has failed to return to the facility on time in accordance with appropriate procedures, the facility shall take immediate action to locate the resident. If the resident cannot be located a report must be filed by the next working day with the referring judicial authority.

4. When a resident leaves the facility for any reason, he shall sign out in the facility resident log. Each entry shall include: resident's name; destination; phone number at destination; address of destination; time out; anticipated time of return; actual time of return; and the initials of the

appropriate staff member charged with monitoring the log book.

5. Facility staff shall ensure that resident work schedules are verified prior to the resident signing out for work.

6. Alcohol/drug testing shall be conducted both randomly and for probable cause. Drug testing shall be conducted monthly on a minimum of 10% of the residents. Costs associated with testing shall be the responsibility of the facility. However, restitution in the amount of the actual cost of the drug testing may be obtained from the resident when the test results are positive.

7. The facility itself shall remain staffed 24 hours a day in such a manner that no person can enter or exit the facility without the knowledge of the on-duty staff.

8. The facility shall have a written emergency plan that is disseminated to the local authorities including but not limited to the local police and fire department.

9. The facility shall have disciplinary rules and procedures available to the resident population.

10. Program access and administrative decisions shall be made without regard to resident's race, religion, national origin or sex. The facility shall have written policy, procedure and practice to protect residents from personal abuse, corporal punishment, personal injury, disease, property damage and harassment.

11. Possession and use of weapons is prohibited in the facility except in the event of an emergency.

12. A written report shall be prepared following all uses of force detailing all circumstances, listing all involved, including witnesses and describing medical services provided. Such reports shall be submitted to the facility administrator and maintained on file.

#### E. Facility Services

1. Written policy, procedure and practice shall require that dietary allowances are reviewed at least annually by a qualified nutritionist, dietician or physician to ensure that they meet the nationally recommended allowances for basic nutrition for the type of residents housed at the facility. Records shall be maintained for all meals served. Three meals shall be provided at regular meal times during each 24 hour period for residents present in the facility at such meal time. Variations may be allowed based on weekend and holiday food service demands provided basic nutritional goals are met. Residents shall be provided an ample opportunity to eat.

2. The denial of food as a disciplinary measure is prohibited. Special diets as prescribed by appropriate medical or dental personnel shall be provided.

3. The facility shall have a written housekeeping and maintenance plan that provides for the ongoing cleanliness and sanitation of the facility, including a plan for the control of vermin and pests.

4. The facility has an obligation to ensure that the resident has adequate clothing appropriate to the season and the resident's work status, including adequate changes of clothing to allow for regular laundering.

5. The facility shall provide adequate bedding and linens including two sheets, pillow and pillowcase, one mattress and sufficient blankets to provide comfort under existing temperature controls. Residents shall have access to personal hygiene articles including soap, towels, toothbrush,

toothpaste, comb, toilet paper, shaving gear and/or feminine hygiene articles.

6. The facility shall have written policy, procedure and practice for the delivery of health care services, including medical, dental and mental health services under the control of a designated health care authority that may be a physician, a licensed or registered health care provider or health agency. Access to these services are available 24 hours per day in case of emergency and should be unimpeded in the sense that non-medical staff should not approve or disapprove residents requests for services in accordance with the facility's health care plan.

7. Anyone providing health care services to residents shall be licensed, registered or certified as appropriate to their respective professional disciplines. Such personnel may only practice as authorized by their license, registration or certification. Standing or direct orders may be used in the treatment of residents only when authorized in writing by a physician or dentist.

8. Personnel who do not have health care licenses may only provide limited health care services as authorized by the designated health care authority and in accordance with appropriate training and job description. This would typically involve the administration of medication, the following of standing orders as authorized by the designated health care authority and the administration of first aid/CPR.

9. The facility shall provide access to 24 hour emergency medical services. This requirement may be met by agreement with a local hospital, on-call qualified health care personnel or on-duty qualified health care personnel.

10. All residents entering the program shall receive a health screening. The purpose of the health screening is to protect newly admitting residents who pose a health safety threat to themselves or others from not receiving adequate medical attention.

11. The facility shall have a method in place for the proper management of pharmaceuticals. Residents are provided medication as ordered by the prescribing physician.

12. First aid kits shall be available in areas of the facility as designated by the health care authority. Contents and locations are approved by the health authority.

13. Sick call shall be conducted by a physician and/or other qualified health care personnel who are licensed, registered or certified as appropriate to their respective professional disciplinary and who practice only as authorized by their license, registration or certification.

14. There is a written suicide prevention and intervention program that is approved by a medical or mental health professional who meets the educational and license/certification criteria specified by his/her respective professional discipline. All staff with responsibility for resident supervision are trained in the implementation of the program.

15. Written policy, procedure and practice shall specify and govern the actions to be taken in the event of a resident's death.

16. Residents shall not participate in medical, pharmaceutical or cosmetic experiments. This does not preclude individual treatment of a resident based on the need for a specific medical procedure that is not generally available.

## F. Resident Programs

1. Educational programming shall be available from acceptable internal or external sources which shall include, at a minimum, assistance in obtaining individualized program instruction at a variety of levels.

2. Written policy, procedure and practice shall govern resident correspondence. Such policy shall include provisions for inspection of mail for contraband or deterrence of material that interferes with legitimate facility objectives. Written policy, procedure and practice govern resident access to publications and packages from outside sources. Staff members shall have access to policies concerning resident correspondence.

3. Written policy, procedure and practice govern visiting. The only time an approved visitor can be denied a visit is where there is substantial evidence that the visitor poses a threat to the safety of the resident or the security of the program.

4. Reading materials shall be available to residents on a reasonable basis.

5. Residents shall have an opportunity for religious practice.

6. Recreation and leisure time activities are available to meet the need of the residents.

7. Substance abuse services through community referrals shall be provided, along with adequate monitoring, for residents identified through assessment who have alcohol and/or drug abuse problems.

8. The facility shall have a grievance procedure with at least one level of appeal. However, if the resident is not satisfied with the outcome of the facility's internal decision they shall be allowed to appeal to the referring judicial agency.

## G. Employment

1. There need be no general restriction on the types of jobs for which a resident may be considered. Each job offer shall be investigated to determine if it is bona fide and consistent with program policies. The expectation is that the job selected shall be that which best fulfills the purpose of the program. Good employment placement shall give preference to jobs that are related to prior training and are suitable for continued employment. All employment plans must be consistent with state statutes. Concern for public safety shall guide employment decisions at all times. No resident is to work for or on the premises of a school, day care facility or other business or agency whose primary objective is in the service of juveniles, or who provide housing, care and/or treatment of juveniles.

2. Other than noted above, there are no general restrictions on the types of jobs residents may be considered for except those relative to juveniles; however, common sense and logic must prevail. At all times, concern for public safety shall guide the decision. Residents shall not be employed in a bar, lounge or tavern as a bartender, waiter or janitor. Employment in a hotel, motel or restaurant where a lounge is a part of the establishment may be acceptable if the employment is verified by the facility and is determined to be appropriate.

3. No resident shall be employed in a position which would necessitate his/her departure from the state of Louisiana without the express consent of the probation and

parole officer, district attorney and/or the court, whichever is applicable.

4. Every reasonable effort shall be made by the facility to provide residents with the highest paying job possible. Within reason, convenience of job location, as it pertains to the facility providing transportation, should not be a deciding factor as to where residents are employed.

5. Residents shall be assisted by facility staff in obtaining gainful employment. The facility shall be responsible for maintaining liaison with sources of information on available jobs and with potential employers, and will provide transportation for job interviews.

6. All employers must sign the employer's work agreement form which indicates the terms and rules of the resident's employment, prior to the resident reporting to work for the employer. The facility must explain the requirements contained in the Employer's Work Agreement to all approved employers. A copy of the signed form shall be kept on file for the duration of the resident's stay at the facility. The employer agrees to report any attendance irregularities to the facility immediately and record same.

7. The employer must agree to provide a work situation where he or his designee, preferably a supervisor, shall be present with the resident or at the work site at all times. Employment that does not provide for proper supervision of the resident and/or is deemed unsuitable by the facility director may be terminated.

8. The employer's responsibility to provide proper supervision for the resident extends from the time the employer receives the resident from facility personnel, either by picking him up at the facility or by having facility personnel transport the resident to the employer, and terminates when he returns the resident back to the facility personnel, either at the facility or to facility provided transportation. The ideal situation is for no resident to be unsupervised during the transportation process to or from an employment location. However, there may be a reasonable time (defined as less than an hour) allowed before work (when a resident is dropped off) and after work (when the resident is picked up) that he may be unsupervised.

9. Should the occasion arise and a resident is not picked up in a reasonable period of time, it must be noted on the transportation log with the reason why.

10. The facility is required to keep a list, which is updated weekly, of every employer who provides work for residents assigned to that facility. This list shall include but not be limited to the name and address of the employer, a brief description of the nature of the business, relevant telephone number(s) and whether or not work is performed at a stationary location or if the resident will be required to move during the course of the day.

11. If the resident's estimated time of return changes for any reason, this change must be verified by facility staff with the employer and noted in the permanent log.

#### H. Community Involvement

1. Community involvement and volunteers can be an important contribution to any program by providing a number of services to residents, as well as serving as a link between the facility and the community. Community resources should be obtained through referrals or by contract to provide residents with services to meet their needs.

2. Policies and procedures regarding citizen involvement shall be developed and volunteers shall be subject to approval by the facility administrator.

3. The facility shall have an advisory board that is representative of the community in which it is located that meets at least annually. The local Department of Public Safety and Corrections Probation and Parole Office, shall designate a staff person to serve on this board.

#### I. Resident Activities

##### 1. Permanent Log

a. A permanent log shall be maintained which shall indicate when residents report to and leave work and shall list events, messages, telephone calls, unusual incidents, counts, meals, etc. This permanent log shall be maintained continuously by the careworker staff. All resident work schedules shall be verified by facility staff prior to the resident being logged out for work.

##### 2. Resident Log

a. A daily resident log shall be maintained which shall indicate when residents leave and return to the facility for any reason. The resident shall sign out in the facility log book. Each entry shall include: residents' name; destination; phone number at destination; address at destination; time out; anticipated time of return; actual time of return; and the resident's signature upon return. The employee on duty shall initial each entry when the resident leaves the facility and when he returns. A clock with the correct time shall be visible to both the resident and the employee and shall serve as the official timepiece. This daily resident log will begin at 12:00 midnight and cover a 24 hour period. Resident logs shall be kept on file for at least three years.

b. Random pat searches shall be conducted in such a manner so as to discourage the introduction of contraband into the facility. Random pat searches and alcohol breath tests shall be administered by a staff member to the resident population each day as they return to the facility. All searches and breath tests shall be entered on the permanent log.

#### J. Resident Discipline

1. Residents assigned to the program shall comply with all rules and procedures set forth by the facility. Each resident shall receive a copy of the facility handbook and any other rules and regulations of the facility's program, including disciplinary procedures available to the staff, which the resident is required to read. The resident shall sign and date a statement acknowledging this, which is placed in his file.

2. All of the above shall be provided to the resident prior to his voluntary entry into the program.

3. The facility's disciplinary process shall be defined and provide appropriate procedural safeguards as outlined in the applicable ACA standards. The facility shall have a process for informal resolution of minor infractions of facility rules. Residents charged with major rule violations shall receive a written statement of the alleged violation(s), including a description of the incident and specific rules violated. The facility is responsible for ensuring that disciplinary reports are completed accurately and staff completing reports shall receive training on report writing. A supervisor shall review disciplinary reports prior to submission making certain essential elements (who, what,

when, where, etc.) are covered with clarity. It is essential that reports be accurate as residents are subject to removal from the facility program for serious violations.

#### 4. Restriction of Privileges

a. When residents are found guilty of a rule violation and are assessed penalties which restrict their privileges, the privileges which are restricted and the amount of time imposed shall be posted in a conspicuous place so that all staff members are aware of the restrictions. Under no circumstances shall privileges be restricted without a proper disciplinary report, a due process hearing and a finding of guilty. The denial of food shall not be used as a disciplinary measure.

b. The resident shall be allowed to appeal the disciplinary process. If they are not satisfied with the outcome of the appeal, they shall be allowed to appeal to the referring judicial agency.

#### K. Resident's Personal Funds

##### 1. General

a. In keeping with the goals and objectives of the residential program, the facility shall ensure as much of the resident's earned net wages as possible are maintained and available to the resident immediately upon release.

b. Funds held on behalf of the resident shall be properly accounted for. The collection and disbursement of the residents' wages shall be in accordance with the provisions of La. R.S. 15:1111. The methods used for the receipt, safeguarding, disbursement and recording of funds shall comply with generally accepted accounting principles.

c. A ledger shall be maintained reflecting the financial status of each resident in the facility, and there shall be adequate documentation to support the receipt/expenditure of resident funds in each resident's official file.

d. Each facility shall engage in an independent financial audit of all funds received and held on behalf of residents at least every three years. The DPS&C monitoring team visits or audits conducted by the DPS&C Internal Audit Division shall not be considered an independent audit for this purpose. The cost of the independent financial audit shall not be paid from the resident trust account.

e. The resident trust account is subject to review or audit by the DPS&C and/or the Office of the Governor, Division of Administration Auditor at any time.

##### 2. Management of Resident Funds

###### a. Bonding

i. The facility shall provide the Department with certificates of bonding documenting coverage sufficient to safeguard the maximum amount of resident funds staff may be responsible for handling.

###### b. Resident Trust Fund Account Management

i. The balance in the resident trust account shall represent only the funds owed to the residents. Resident funds shall not be used for other purposes (i.e., pay operational expenses) or be commingled with other bank accounts. Likewise, the trust account shall not be used to maintain other monies, such as for resident organizations, seized contraband, investments or a "slush" fund.

(a) Start up costs for each new resident shall not be paid from the resident trust account. These costs shall be paid from the facility's operating fund account, to be

reimbursed by the resident once the resident begins receiving wages.

(b) The resident trust account cash balance shall be maintained at the appropriate balance to cover each resident's account balance.

(c) Signers on the resident trust account shall be an employee or other legal stakeholders of the facility. The number of signers on the account shall not exceed three people.

(d) The resident trust account shall not be a "sweep account" or used in conjunction with "sweep accounts."

(e) On a monthly basis the following actions must occur:

(i) Transfer out any interest earned on the Trust account. The interest earnings are property of the facility. Such interest earnings may be used to help defray administrative costs and to provide for other expenditures which will benefit the resident population.

(ii) Transfer out amounts owed by residents for the daily room and board per diem.

(iii) Transfer out amounts owed by residents to vendors to be paid from the operating account or pay the resident's expenses directly from the trust account.

(iv) Reimburse trust account for expenses for bank service charges/fees (including fees for check orders) from the facility's operating fund account.

(v) Reimburse trust account from the facility's operating fund account for any negative resident balances being paid with trust fund money. Residents who are allowed to spend more money than their current balance cannot use trust account funds to pay their debts; therefore, it becomes an operational expense.

(vi) Provide a detailed statement of account balance to the resident in a confidential manner.

(vii) Reconcile the trust account after receipt of the monthly bank statement:

[a] add all deposits and deduct all withdrawals to each individual ledger to determine each resident's current balance;

[b] total current month's positive balances for all resident ledgers, including balances carried forward from previous months which have had no transactions in the current month;

[c] compare this total to the reconciled bank balance;

[d] investigate and resolve any discrepancies between the bank and the resident ledger.

##### 3. Income and Wages Received

a. The facility shall ensure employers adhere to the signed employer's work agreement by verifying rates of pay, hours worked and pay received by the resident for each pay period worked.

b. The facility shall ensure that the resident is paid by the employer by either a manual check sent directly to the facility or direct deposit to the resident trust account at the facility.

c. Residents shall not be allowed to receive payment from the employer via a pay card (pre-paid credit and/or ATM card) issued to the resident.

d. The facility shall process all personal funds received on behalf of the residents, issue pre-numbered

receipts for funds and post receipts to the resident's account indicating receipt number.

e. Funds received shall be deposited daily (within 24 hours with the exception of weekends and holidays) into a fiduciary account held in trust for the residents and designated specifically as "Resident Trust Account." Credits shall be posted to the resident ledger within two (2) business days.

f. Sensitive banking transactions involving the facility banking information and resident shall be handled directly between the facility and the employer, not between the resident and the employer.

#### 4. Expenses and Withdrawals

a. All withdrawals or expenditures by a resident shall be documented by a withdrawal request form, signed and dated by the resident and document approval or denial of request by facility personnel. Withdrawals/expenditures shall be posted to the resident ledgers at least weekly with an adequate description relating to all transactions.

b. As one of the goals of a judicial agency referral residential program is to provide residents with the opportunity to accumulate savings as they prepare for reentry, facility managers have a fiduciary responsibility to set limitations on spending to maximize the potential savings of a resident.

c. Facilities shall develop procedures that set limitations and/or spending limits on resident purchases from canteen/commissary operations that encourage the resident to maximize on the opportunity to accumulate savings prior to release from the program.

#### 5. Deductions

a. Residents shall be charged a daily rate not to exceed \$62.50 per day for services provided by the facility which includes room and board, transportation, education and all other necessary services. Medical and Mental Health services may be the responsibility of the resident. However, a lack of funds shall not interfere with the resident receiving these services. The resident shall not be charged for any additional costs other than those authorized in this document. Documentation of all deductions shall be maintained in each resident's file.

#### 6. Other Deductions Allowed

a. Allowance: The facility shall develop procedures to determine the weekly allowance needed for incidental personal expenses in accordance with provisions in this Chapter. Residents should be encouraged to refrain from unnecessary purchases in order that they may be able to accrue savings to be available to them upon completion of the program.

b. Support of the resident's dependents: The resident and facility shall mutually agree upon the amount to be sent to dependents. This agreement and authorization shall be in writing.

c. Legal Judgments: If there is a legal judgment of support, that judgment shall suffice as written authorization to disburse the money.

d. Payment of the resident's obligations: Debts acknowledged by the resident shall be in writing or reduced to judgment (including victim restitution) and shall reflect the schedule by which the resident wishes the debt to be repaid. The facility shall ensure that payment of this type debt is legitimate.

e. Canteen/commissary items shall be priced at a reasonable cost to residents. Contractors that operate a canteen shall provide to the facility administrator a list of canteen items sold and the price list of the cost of the item to the resident.

#### L. Sexual Assault and Sexual Misconduct

##### 1. Prohibited Conduct: Sexual Contact between Staff, Civilians and Residents

a. There is no consensual sex in a custodial or supervisory relationship. Any sexual assault, sexual misconduct or sexual coercion between staff, civilians and residents is inconsistent with professional, ethical principles and department regulations. Acts of sexual assault, sexual misconduct or sexual coercion by staff or civilians against residents under their supervision is a violation of R.S. 14:134 et seq., subject to criminal prosecution. Retaliation against individuals because of their involvement in the reporting or investigation of sexual assault, sexual misconduct or sexual coercion is strictly prohibited.

##### 2. Facility Policy

a. The facility shall have written policies and procedures for the prevention, detection, response, reporting and investigating of alleged and substantiated sexual assaults. Facility investigative reports of such allegations shall be submitted to the judicial agency which referred the resident to the facility.

#### M. Department of Public Safety and Corrections Facility Access

##### 1. Compliance Monitoring

a. In accordance with R.S. 40:2852, all judicial agency referral residential facilities shall be regulated by rules adopted and enforced by the Department of Public Safety and Corrections for the operation of such facilities. In order to fulfill this mission, the department must have the ability to inspect the facility on a scheduled or random basis. The inspections shall include but not be limited to: review of ACA files; review of log books; resident employment status; quality of life issues; resident financial information and any information necessary to ensure compliance with both ACA standards and the standard operating procedures for judicial agency referral residential facilities.

##### 2. Access to DPS&C Staff

a. The Division of Probation and Parole shall have access as necessary to any residents on probation in the program to ensure compliance with conditions of probation. This includes the need for regular contacts, random drug screening and any other duties necessary to determine that the resident is abiding by the conditions of their probation.

b. The DPS and C shall have access to the facility at any time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:667 (April 2007), amended LR 37:

#### **§1305. Physical Plant**

##### Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:667 (April 2007), repealed LR 37:

**§1307. Facility Operations**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:667 (April 2007), repealed LR 37:

**§1309. Facility Services**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:668 (April 2007), repealed LR 37:

**§1311. Resident Programs**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:669 (April 2007), repealed LR 37:

**§1313. Employment**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:669 (April 2007), repealed LR 37:

**§1315. Community Involvement**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:670 (April 2007), repealed LR 37:

**§1317. Resident Activities**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:670 (April 2007), repealed LR 37:

**§1319. Resident Discipline**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:670 (April 2007), repealed LR 37:

**§1321. Resident Personal Funds**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2851 and 2852.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:671 (April 2007), repealed LR 37:

James M. Le Blanc  
Secretary

1101#034

**DECLARATION OF EMERGENCY**

**Department of Wildlife and Fisheries  
Wildlife and Fisheries Commission**

**2011-12 Commercial King Mackerel Season**

In accordance with the provisions of R.S. 49:953 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to employ emergency procedures to establish seasonal rules to set finfish seasons, R.S. 56:6(25)(a) and 56:326.3 which provide that the Wildlife and Fisheries Commission may set seasons for saltwater finfish; the Wildlife and Fisheries Commission hereby sets the following season for the commercial harvest of king mackerel in Louisiana state waters:

The commercial season for king mackerel in Louisiana state waters will open at 12:01 a.m., July 1, 2011 and remain open until the allotted portion of the commercial king mackerel quota for the western Gulf of Mexico has been harvested or projected to be harvested.

The commission grants authority to the Secretary of the Department of Wildlife and Fisheries to close the commercial king mackerel season in Louisiana state waters when he is informed by the National Marine Fisheries Service (NMFS) that the commercial king mackerel quota for the western Gulf of Mexico has been harvested or is projected to be harvested, such closure order shall close the season until 12:01 a.m., July 1, 2012, which is the date expected to be set for the re-opening of the 2012-13 commercial king mackerel season in Federal waters.

The commission also authorizes the Secretary to open additional commercial king mackerel seasons in Louisiana state waters if he is informed that NMFS has opened such additional seasons and to close such seasons when he is informed that the commercial king mackerel quota for the western Gulf of Mexico has been filled, or is projected to be filled.

Effective with seasonal closures under this rule, no person shall commercially harvest, possess, purchase, exchange, barter, trade, sell, or attempt to purchase, exchange, barter, trade, or sell king mackerel, whether taken from within or without Louisiana territorial waters. Also effective with this closure, no person shall possess king mackerel in excess of a daily bag limit, which may only be in possession during the open recreational season by legally licensed recreational fishermen. Nothing shall prohibit the possession or sale of fish by a commercial dealer if legally taken prior to the closure providing that all commercial dealers possessing such fish taken legally prior to the closure shall maintain appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6.

Stephen J. Oats  
Chairman

1101#043

## DECLARATION OF EMERGENCY

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Coastal Sharks Commercial Fishery Opening

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, and the authority given to the Secretary of the Department by the Commission in its rule LAC 76:VII.357.M.2 which allows the Secretary to establish seasons, the Secretary of the Department of Wildlife and Fisheries hereby declares:

Effective 12:01 a.m., January 1, 2011, the commercial fishery for Non-Sandbar Small Coastal Sharks, (bonnethead shark, Atlantic sharpnose shark, blacknose shark, finetooth shark) in Louisiana waters as described in LAC 76:VII.357.B.2 will open and remain open until the federally established quota is harvested or expected to be harvested, unless the federal season for a species or species group in the Gulf of Mexico is closed, and the Secretary is requested by NOAA Fisheries to take action to enact consistent seasonal regulations.

Effective 12:01 a.m., March 1, 2011, the commercial fishery for Non-Sandbar Large Coastal Sharks (great hammerhead, scalloped hammerhead, smooth hammerhead, nurse shark, blacktip shark, bull shark, lemon shark, silky shark, spinner shark and tiger shark) in Louisiana waters as described in LAC 76:VII.357.B.2 will open and remain open until the federally established quota is harvested or expected to be harvested, unless the federal season for a species or species group in the Gulf of Mexico is closed, and the Secretary is requested by NOAA Fisheries to take action to enact consistent seasonal regulations.

Louisiana has a fixed closed season for the commercial and recreational harvest of all sharks from April 1 through June 30 of each year for protection of pupping and nursery areas, which we believe appropriate to maintain for conservation purposes.

Effective with these openings, properly licensed and permitted persons may commercially harvest, possess, and sell Non-Sandbar Small Coastal Sharks and Non-Sandbar Large Coastal Sharks whether taken from within or without Louisiana waters in compliance with the rules as set forth by the National Marine Fisheries Service for Federal waters, and by the Louisiana Wildlife and Fisheries Commission. Only properly licensed and permitted dealers may purchase Non-Sandbar Small Coastal Sharks and Non-Sandbar Large Coastal Sharks during the open season. The fishery for both Non-Sandbar Small Coastal Sharks and Non-Sandbar Large Coastal Sharks in Louisiana state waters will be closed from April 1 through June 30.

The secretary has been notified by the National Marine Fisheries Service that the season for commercial harvest of Non-Sandbar Small Coastal Sharks in the federal waters of

the Gulf of Mexico will open on January 1, 2011 and that the commercial fishery for Non-Sandbar Large Coastal Sharks in the federal waters of the Gulf of Mexico will open on March 1, 2011.

Robert J. Barham  
Secretary

1101#021

## DECLARATION OF EMERGENCY

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Fall Inshore Shrimp Season Extension in Portions of Zone 1

In accordance with the emergency provisions of R.S. 49:953 of the Administrative Procedure Act which allows the Wildlife and Fisheries Commission to use emergency procedures to set shrimp seasons and R.S. 56:497 which allows the Wildlife and Fisheries Commission to delegate to the Secretary of the Department the powers, duties and authority to set seasons, and in accordance with a Declaration of Emergency adopted by the Wildlife and Fisheries Commission on August 5, 2010 which authorized the Secretary of the Department of Wildlife and Fisheries to change the closing dates of the 2010 Fall Inshore Shrimp Season if biological and technical data indicate the need to do so, the Secretary of the Department of Wildlife and Fisheries does hereby declare that the 2010 fall inshore shrimp season in that portion of Shrimp Management Zone 1 including Lake Pontchartrain, Rigolets Pass, Chef Menteur Pass, the Mississippi River Gulf Outlet (MRGO), that part of Lake Borgne seaward of a line extending one-half mile from the shoreline, and that portion of Mississippi Sound beginning at a point on the Louisiana-Mississippi Lateral Boundary at 30 degrees 09 minutes 39.6 seconds north latitude and 89 degrees 30 minutes 00.0 seconds west longitude; thence due south to a point at 30 degrees 05 minutes 00.0 seconds north latitude and 89 degrees 30 minutes 00.0 seconds west longitude; thence southeasterly to a point on the western shore of Three-Mile Pass at 30 degrees 03 minutes 00.0 seconds north latitude and 89 degrees 22 minutes 23.0 seconds west longitude; thence northeasterly to a point on Isle Au Pitre at 30 degrees 09 minutes 20.5 seconds north latitude and 89 degrees 11 minutes 15.5 seconds west longitude, which is a point on the double-rig line as described in LA R.S. 56:495.1(A)2; thence northerly along the double-rig line to a point on the Louisiana-Mississippi Lateral Boundary at 30 degrees 12 minutes 37.9056 seconds north latitude and 89 degrees 10 minutes 57.9725 seconds west longitude; thence westerly along the Louisiana-Mississippi Lateral Boundary to the point of beginning shall be extended until further notice effective December 13, 2010.

Robert J. Barham  
Secretary

1101#022

## DECLARATION OF EMERGENCY

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Reef Fish—Harvest Regulations  
2011-2012 Recreational Reef Fish Seasons

The reef fish fishery in the Gulf of Mexico is cooperatively managed by the Department of Wildlife and Fisheries (LDWF), the Wildlife and Fisheries Commission (LWFC) and the National Marine Fisheries Service (NMFS) with advice from the Gulf of Mexico Fishery Management Council (Gulf Council). Regulations promulgated by NMFS are applicable in waters of the Exclusive Economic Zone (EEZ) of the U.S., which in Louisiana is generally three miles offshore. NMFS typically requests consistent regulations in order to enhance the effectiveness and enforceability of regulations for EEZ waters.

Recreational season rules have been established for red snapper in the Gulf of Mexico and in Louisiana state waters. No established season has been promulgated for greater amberjack, but both fisheries operate under recreational quotas. If the quota is projected to be reached, NMFS is required by law to close the season to restrain fishing within the established quota for the species.

Adoption of compatible regulations for Louisiana state waters where feasible enhances effectiveness and enforceability of the regulations already in place for reef fishes harvested in the EEZ off of Louisiana. Unforeseen circumstances may occur which may lead to modification of the recreational seasons to restrain the fisheries within the recreational quota, requiring a modification in established regulations.

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to employ emergency procedures to promulgate seasonal rules to set finfish seasons, and R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, the Wildlife and Fisheries Commission hereby declares:

The Secretary of the Department of Wildlife and Fisheries is hereby authorized to close the season for the recreational harvest of red snapper or greater amberjack in Louisiana state waters if he is informed by the Regional Administrator of NMFS that the applicable recreational quota has been harvested or is projected to be harvested in the Gulf of Mexico and the recreational season closed in Federal waters of the Gulf of Mexico, and if he is requested by the Regional Administrator of NMFS that the State of Louisiana enact compatible regulations in Louisiana state waters.

The commission also hereby grants authority to the Secretary of the Department of Wildlife and Fisheries to modify the recreational season currently established in Louisiana state waters if he is informed by NMFS that the season dates for the recreational harvest of red snapper or greater amberjack in the Federal waters of the Gulf of Mexico as set out herein have been modified, and that NMFS requests that the season be modified in Louisiana

state waters. Such authority shall extend through January 31, 2012.

Stephen J. Oats  
Chairman

1101#037

## DECLARATION OF EMERGENCY

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Reef Fish—Harvest Regulations  
2011-2012 Reef Fish Commercial Seasons

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, and R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, the Wildlife and Fisheries Commission hereby declares:

The commercial fishing seasons for reef fish as listed in LAC 76:VII.335, Reef Fish—Harvest Regulations continue to remain open as of January 1 of each year unless otherwise provided for in LAC 76:VII.335 and LAC 76:VII.337, or as a result of actions by the Secretary as authorized below. These commercial fishing seasons include closed seasons for some species and species groups as listed in LAC 76:VII.335 and in LAC 76:VII.337, including prohibition on harvest of goliath and Nassau groupers.

The Secretary of the Department of Wildlife and Fisheries is hereby authorized to close the season for the commercial harvest of any species or group of species of the fishes listed in LAC 76:VII.335, Reef Fish – Harvest Regulations, in Louisiana state waters if he is informed by the Regional Administrator of NMFS that the applicable commercial quota has been harvested in the Gulf of Mexico, and if he is requested by the Regional Administrator of NMFS that the State of Louisiana enact compatible regulations in Louisiana state waters.

The commission also hereby grants authority to the Secretary of the Department of Wildlife and Fisheries to modify the commercial seasons described here in Louisiana state waters if he is informed by NMFS that the season dates for the commercial harvest of these fish species in the Federal waters of the Gulf of Mexico as set out herein have been modified, and that NMFS requests that the season be modified in Louisiana state waters. Such authority shall extend through January 31, 2012.

Effective with seasonal closures under this Emergency Rule, no person shall commercially harvest, possess, purchase, exchange, barter, trade, sell, or attempt to purchase, exchange, barter, trade, or sell the affected species of fish, whether taken from within or without Louisiana territorial waters. Also effective with these closures, no person shall possess the affected species of fish in excess of a daily bag limit, which may only be in possession during the open recreational season by legally licensed recreational fishermen. Nothing shall prohibit the possession or sale of

fish by a commercial dealer if legally taken prior to the closure providing that all commercial dealers possessing such fish taken legally prior to the closure shall maintain appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6.

Stephen J. Oats  
Chairman

1101#041

## DECLARATION OF EMERGENCY

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Reef Fish—Harvest Regulations Gag Grouper Recreational Season Closure

The reef fish fishery in the Gulf of Mexico is cooperatively managed by the Department of Wildlife and Fisheries (LDWF), the Wildlife and Fisheries Commission (LWFC) and the National Marine Fisheries Service (NMFS) with advice from the Gulf of Mexico Fishery Management Council (Gulf Council). Regulations promulgated by NMFS are applicable in waters of the Exclusive Economic Zone (EEZ) of the U.S., which in Louisiana is generally three miles offshore. An interim rule was established by NMFS to close the recreational gag grouper season in order to reduce overfishing on gag grouper. The NMFS interim rule is effective for six months until May 31, 2011 but may be extended an additional six months up through the remainder of 2011 while the Gulf Council develops a long-term rebuilding plan through Amendment 32 to the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico. NMFS has requested consistent regulations in order to enhance the effectiveness and enforceability of regulations for EEZ waters.

In order to enact regulations in a timely manner so as to have compatible regulations in place in Louisiana waters to coincide with the regulation set forth by NMFS, it is necessary that emergency rules be enacted.

In accordance with the emergency provisions of R.S. 49:953, the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, and R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, the Wildlife and Fisheries Commission hereby declares:

The recreational fishery for gag grouper will close in Louisiana waters effective 12:01 a.m., January 10, 2011, and shall remain closed until further notice. Effective with this closure, no person shall recreationally harvest or possess gag grouper whether within or without Louisiana waters.

The commission also hereby grants authority to the Secretary of the Department of Wildlife and Fisheries to modify the recreational season currently established in Louisiana state waters if he is informed by NMFS that the season dates for the recreational harvest of gag grouper in the Federal waters of the Gulf of Mexico as set out herein have been modified, and that NMFS requests that the season

be modified in Louisiana state waters. Such authority shall extend through January 31, 2012.

Stephen J. Oats  
Chairman

1101#042

## DECLARATION OF EMERGENCY

### Workforce Commission Office of Workers' Compensation

#### Medical Guidelines (LAC 40:I.Chapters 20-23)

The Louisiana Workforce Commission, Office of Workers' Compensation, has exercised the emergency provision in accordance with LA. R.S. 49:953(B), the Administrative Procedure Act, to adopt LAC 40:I, Chapters 20-23. This emergency rule will be effective January 1, 2011.

House Bill 1138, Act No. 619, of the 2010 Regular Session of the Louisiana Legislative Session, states that "the Director shall, through the Office of the Workers' Compensation Administration, promulgate rules...to establish a medical treatment schedule no later than January 1, 2011". Failure to promulgate the rules by January 1, 2011, would result in significant uncertainty among medical providers and insurers as to which procedures would be approved under the medical guidelines. Such uncertainty would cause a delay in services to injured workers and impair their ability to return to the workforce. Accordingly it is necessary to timely implement the rules by virtue of emergency rule.

Notice is hereby given, in accordance with R.S. 49:950, et seq., that the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to authority vested in the Director of the Office of Workers' Compensation by R.S. 23:1310.1 and in accordance with applicable provisions of the Administrative Procedure Act, proposes to enact LAC 40:I., Subpart 2, Chapters 20-23 to add the following:

- Chapter 20 (Spine Medical Treatment Guidelines): Sections 2001 through 2012 (Cervical Spine Injury) and Sections 2013 through 2024 (Low Back Pain)
- Chapter 21 (Pain Medical Treatment Guidelines):
- Sections 2101 through 2116 (Chronic Pain Disorder) and Sections 2117 through 2136 (Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy)
- Chapter 22 (Neurological and Neuromuscular Disorder Medical Treatment Guidelines) Sections 2201 through 2214 (Carpal Tunnel Syndrome)
- Sections 2215 through 2228 (Thoracic Outlet Syndrome)
- Chapter 23 (Upper and Lower Extremities Medical Treatment Guidelines) Sections 2301 through 2314 (Lower Extremities) and Sections 2315 through 2328 (Shoulder Injuries)

The contents of the new chapters are relative to medical treatment guidelines for the delivery of medical treatment in

workers compensation cases, which are being promulgated in accordance with the directives of La. R.S. 23:1203.1. The proposed enactment is set forth in the attached documents.

#### **Title 40**

### **LABOR AND EMPLOYMENT**

## **Part I. Workers' Compensation Administration**

### **Subpart 2. Medical Guidelines**

## **Chapter 20. Cervical Spine Medical Treatment Guidelines**

### **§2001. Introduction**

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana's Workers' Compensation Act as injured workers with cervical spine injuries. These guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2003. General Guideline Principles**

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer, and patient through the Office of Worker's Compensation.

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of cervical spine injuries and disability. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. Treatment Parameter Duration. Time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

4. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation Treatment Every three to four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling,

crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. **Delayed Recovery.** Delayed recovery strongly considers a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. **Guideline Recommendations and Inclusion of Medical Evidence.** Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. *Consensus* means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as generally well accepted, generally accepted, acceptable/accepted, or well-established.

b. *Some* means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. *Good* means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. *Strong* means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2005. Initial Diagnostic Procedures

A. The OWCA recommends the following diagnostic procedures be considered, at least initially, the responsibility

of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures, that should be utilized when initially diagnosing a work-related cervical spine complaint, are listed below.

1. **History-taking and physical examination (Hx & PE).** These are generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not complementing each other, the objective clinical findings should have preference. The medical records should reasonably document the following.

a. **History of Present Injury:** A detailed history, taken in temporal proximity to the time of injury, should primarily guide evaluation and treatment. The history should include:

i. **Mechanism of injury.** This includes details of symptom onset and progression. The mechanism of injury should include a detailed description of the incident and the position of the body before, during, and at the end of the incident. Inclusion of normal work body postures, frequency during the workday and lifting/push/pull requirements, should be included in the absence of a known specific incident.

ii. **Location of pain, nature of symptoms, and alleviating/exacerbating factors (e.g. sleep positions).** Of particular importance, is whether raising the arm over the head alleviates radicular-type symptoms. The history should include both the primary and secondary complaints (e.g., primary neck pain, secondary arm pain, headaches, and shoulder girdle complaints). The use of a patient completed pain drawing, Visual Analog Scale (VAS) is highly recommended, especially during the first two weeks following injury to assure that all work related symptoms are being addressed.

iii. **presence and distribution of upper and/or lower extremity numbness, paresthesias, or weakness, especially if precipitated by coughing or sneezing;**

iv. **presence and distribution of upper and/or lower extremity numbness, paresthesias, or weakness, especially if precipitated by coughing or sneezing;**

v. **ability to perform job duties and activities of daily living;**

b. **Past History**

i. **past medical history includes neoplasm, arthritis, and diabetes;**

ii. **review of systems includes neoplasm, arthritis, and diabetes;**

iii. **smoking history;**

iv. **vocational and recreational pursuits;**

v. **history of depression, anxiety, or other psychiatric illness.**

c. **Physical Examination** should include accepted tests and exam techniques applicable to the area being examined, including:

i. **visual inspection, including posture;**

ii. **cervical range-of-motion, quality of motion, and presence of muscle spasm.** Motion evaluation of specific joints may be indicated. Range-of-motion should not be checked in acute trauma cases until fracture and instability

have been ruled out on clinical examination, with or without radiographic evaluation;

- iii. examination of thoracic spine;
- iv. palpation of spinous processes, facets, and muscles noting myofascial tightness, tenderness, and trigger points;

v. motor and sensory examination of the upper muscle groups with specific nerve root focus, as well as sensation to light touch, pin prick, temperature, position and vibration. More than 2 cm difference in the circumferential measurements of the two upper extremities may indicate chronic muscle wasting; and

vi. Deep tendon reflexes. Asymmetry may indicate pathology. Inverted reflexes (e.g. arm flexion or triceps tap) may indicate nerve root or spinal cord pathology at the tested level. Pathologic reflexes include wrist, clonus, grasp reflex, and Hoffman's sign.

d. Relationship to Work: This includes a statement of the probability that the illness or injury is work-related. If further information is necessary to determine work relatedness, the physician should clearly state what additional diagnostic studies or job information is required.

e. Spinal Cord Evaluation: In cases where the mechanism of injury, history, or clinical presentation suggests a possible severe injury, additional evaluation is indicated. A full neurological examination for possible spinal cord injury may include:

- i. Sharp and light touch, deep pressure, temperature, and proprioceptive sensory function;
- ii. strength testing;
- iii. anal sphincter tone and/or perianal sensation;
- iv. presence of pathological reflexes of the upper and lower extremities; or

v. evidence of an Incomplete Spinal Cord Injury Syndrome—

(a). Anterior Cord Syndrome is characterized by the loss of motor function and perception of pain and temperature below the level of the lesion with preservation of touch, vibration, and proprioception. This is typically seen after a significant compressive or flexion injury. Emergent CT or MRI is necessary to look for a possible reversible compressive lesion requiring immediate surgical intervention. The prognosis for recovery is the worst of the incomplete syndromes.

(b). Brown-Sequard Syndrome is characterized by ipsilateral motor weakness and proprioceptive disturbance with contralateral alteration in pain and temperature perception below the level of the lesion. This is usually seen in cases of penetrating trauma or lateral mass fracture. Surgery is not specifically required, although debridement of the open wound may be.

(c). Central Cord Syndrome is characterized by sensory and motor disturbance of all limbs, often upper extremity more than lower, and loss of bowel and bladder function with preservation of perianal sensation. This is typically seen in elderly patients with a rigid spine following hyperextension injuries. Surgery is not usually required.

(d). Posterior Cord Syndrome, a rare condition, is characterized by loss of sensation below the level of the injury, but intact motor function.

vi. Spinal cord lesions should be classified according to the American Spine Injury Association (ASIA) impairment scale.

Asia Impairment Scale
A=Complete: No motor or sensory function is preserved in the sacral segments S4-S5
B=Incomplete: Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5
C=Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3
D=Incomplete: Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a grade of 3 or more
E= Normal: motor and sensory function are normal

vii. A worksheet which details dermatomes and muscle testing required is available from ASIA.

f. Soft Tissue Injury Evaluation. Soft tissue injuries are traumatic injuries to the muscles, ligaments, tendons, and/or connective tissue. The most common mechanism is sudden hyperextension and/or hyperflexion of the neck. Acceleration/deceleration on the lateral plane may also result in one of these syndromes. A true isolated cervical strain is not associated with focal neurological symptoms. The signs and pathophysiology of these injuries are not well understood. Soft tissue injuries may include cervical strain, myofascial syndromes, somatic dysfunction, and fractures. The Quebec Classification is used to categorize soft tissue and more severe cervical injuries.

i. Grade I—neck complaints of pain, stiffness, or tenderness only, without physical signs. Lesion not serious enough to cause muscle spasm. Includes whiplash injury, minor cervical sprains, or strains.

ii. Grade II—neck complaints with musculoskeletal signs, such as limited range-of-motion. Includes muscle spasm related to soft tissue injury, whiplash, cervical sprain, and cervicalgia with headaches, sprained cervical facet joints and ligaments.

iii. Grade III—neck complaints, such as limited range-of-motion, combined with neurologic signs. Includes whiplash, cervicobrachialgia, herniated disc, cervicalgia with headaches.

iv. Grade IV—neck complaints with fracture or dislocation.

2. Imaging of the cervical spine is a generally accepted, well-established and widely used diagnostic procedure. Basic views are the anteroposterior (AP), lateral, right, and left obliques, swimmer's, and odontoid. CT scans may be necessary to visualize C7 and odontoid in some patients. Lateral flexion and extension views are done to evaluate instability but may have a limited role in the acute setting. MRI or CT is indicated when spinal cord injury is suspected. The mechanism of injury and specific indications for the imaging should be listed on the request form to aid the radiologist and x-ray technician. Alert, non-intoxicated patients, who have isolated cervical complaints without palpable midline cervical tenderness, neurologic findings, or other acute or distracting injuries elsewhere in the body, may not require imaging. The following suggested indications are:

a. history of significant trauma, especially high impact motor vehicle accident, rollover, ejection, bicycle, or recreational vehicle collision or fall from height greater than one meter;

b. age over 65 years;

c. suspicion of fracture, dislocation, instability, or neurologic deficit - Quebec Classification Grade III and IV;

d. unexplained or persistent cervical pain for at least 6 weeks or pain that is worse with rest;

e. localized pain, fever, constitutional symptoms, suspected tumor, history of cancer, or suspected systemic illness such as a rheumatic/rheumatoid disorder or endocrinopathy;

3. Laboratory Testing. Laboratory tests are generally accepted, well-established and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, or underlying rheumatologic disorder, connective tissue disorder, or based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. Tests include, but are not limited to:

a. complete blood count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;

b. erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), anti-nuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP), can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder;

c. serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease; and

d. liver and kidney function may be performed for prolonged anti-inflammatory use or other medications requiring monitoring.

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### **§2007. Follow-Up Diagnostic Imaging and Testing Procedures**

A. One diagnostic imaging procedure may provide the same or distinctive information as does another procedure. Therefore, prudent choice of a single diagnostic procedure, a complement of procedures, or a sequence of procedures will optimize diagnostic accuracy, and maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients.

B. All imaging procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis. Clinical information obtained by history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results.

C. Magnetic resonance imaging (MRI), myelography, or computed axial tomography (CT) scanning following myelography may provide useful information for many spinal disorders. When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a

complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging studies are generally accepted, well-established and widely used diagnostic procedures. In the absence of myelopathy, progressive neurological changes or incapacitating pain, imaging usually is not appropriate until conservative therapy has been tried and failed. Six to eight weeks of treatment are usually an adequate period of time before an imaging procedure is in order, but the clinician should use judgment in this regard. When the findings of the diagnostic imaging and testing procedures are not consistent with the clinical examination, clinical findings should have preference. There is good evidence that in the over 40 asymptomatic population, the prevalence of disc degeneration is greater than 50 percent. Disc degeneration, seen as loss of signal intensity on MRI, may be due to age-related biochemical changes rather than structural deterioration, and may not have pathological significance. Disc bulging and posterior disc protrusion, while not rare, is more commonly symptomatic in the cervical spine than in the lumbar spine due to the smaller cervical spinal canal. Mild reduction in the cross-sectional area of the spinal cord may be seen without myelopathy in patients older than 40, therefore, clinical correlation is required. The studies below are listed in frequency of use, not importance.

a. Magnetic Resonance Imaging (MRI) is the imaging study of choice for most abnormalities of the cervical spine. MRI is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. MRI should be performed immediately if there is a question of infection or metastatic disease with cord compression. MRI is contraindicated in patients with certain implanted devices.

b. In general, the high field, conventional, MRI provides better resolution. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist. Specialized MRI Scans:

i. MRI with 3-dimensional reconstruction. On rare occasions, MRI with 3-dimensional reconstruction views may be used as a pre-surgical diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures;

ii. Dynamic-kinetic MRI of the spine. Dynamic-kinetic MRI of the spine uses an MRI unit configured with a top-front open design which enables upright, weight-bearing patient positioning in a variety of postures not obtainable with the recumbent images derived from conventional, closed unit MRI systems. Imaging can be obtained in flexion, extension, and rotation of the spine, as well as in erect positioning. There is a theoretical advantage to imaging sequences obtained under more physiologic conditions than

in the supine position. There is currently ongoing research to establish whether the theoretical advantages of positional and kinetic MRI result in improved sensitivity and specificity in detecting spine pathology. Currently it remains investigational, and is not recommended until the correlation with clinical syndromes is firmly established.

c. Computed Axial Tomography (CT) provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic evaluation. It may sometimes be done as a complement to MRI scanning to better delineate bony osteophyte formation in the neural foramen. CT is usually utilized for suspected cervical spine fracture in a patient with negative plain films, or to further delineate a cervical fracture. CT scanning is also quite useful for congenital anomalies at the skull base and at the C1-2 levels. Plain CT scanning is poor for the C6-7 or C7-T1 levels because of shoulder artifact. Instrument-scatter reduction software provides better resolution when metallic artifact is of concern.

d. Myelography is the injection of radiopaque material into the spinal subarachnoid space, with x-rays then taken to define anatomy. It may be used as a diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures. Myelography is an invasive procedure with complications including nausea, vomiting, headache, convulsion, arachnoiditis, CSF leakage, allergic reactions, bleeding, and infection. Therefore, myelography should only be considered when CT and MRI are unavailable, for morbidly obese patients or those who have undergone multiple operations, and when other tests prove non-diagnostic. The use of small needles and a less toxic, water-soluble, nonionic contrast is recommended.

e. CT Myelogram provides more detailed information about relationships between neural elements and surrounding anatomy and is appropriate in patients with multiple prior operations or tumorous conditions.

f. Single Photon Emission Computerized Tomography (SPECT) A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans & CT Scans in looking for facet joint pathology.

g. Bone Scan (Radioisotope Bone Scanning) is generally accepted, well-established and widely used. Bone scanning is more sensitive but less specific than MRI. <sup>99m</sup>Tc diphosphonate uptake reflects osteoblastic activity and may be useful in diagnosing metastatic/primary bone tumors, stress fractures, osteomyelitis, and inflammatory lesions, but cannot distinguish between these entities. In the cervical spine, the usual indication is to evaluate for neoplastic conditions. Other indications include occult fracture or infection.

h. Other Radioisotope Scanning Indium and gallium scans are generally accepted, well-established, and widely used procedures, usually to help diagnose lesions seen on other diagnostic imaging studies. <sup>67</sup>Ga citrate scans are used to localize tumor, infection, and abscesses. <sup>111</sup>In leukocyte scanning is utilized for localizing infection or inflammation and is usually not used for the cervical spine.

i. Dynamic [Digital] Fluoroscopy Dynamic [Digital] Fluoroscopy of the cervical spine measures the motion of intervertebral segments using a videofluoroscopy unit to capture images as the subject performs cervical flexion and extension, storing the anatomic motion of the spine in a computer. Dynamic Fluoroscopy may be used in state-designated trauma centers to evaluate the cervical spine. Its superiority over MRI has not been established. If performed, full visualization of the cervical spine (C1 - T1), in accordance with Section C. 2. (Initial Diagnostic Procedures-Imaging), should be accomplished prior to the procedure. In the post-acute setting in some rare cases, Dynamic [Digital] Fluoroscopy may be used but is primarily an investigational tool and therefore, requires prior authorization in the post-acute setting. No studies have yet demonstrated predictive value in terms of standard operative and non-operative therapeutic outcomes.

2. Other Tests. The following diagnostic procedures are listed in alphabetical order, not by importance.

a. Electrodiagnostic Testing

i. Electromyography (EMG), and Nerve Conduction Studies. (NCS). These are generally accepted, well-established and widely used diagnostic procedures. EMG and NCS, when performed and interpreted by a trained physician/electrophysiologist, may be useful for patients with suspected neural involvement whose symptoms are persistent or unresponsive to initial conservative treatments. They are used to differentiate peripheral neural deficits from radicular and spinal cord neural deficits and to rule out concomitant myopathy. However, F-Wave Latencies are not diagnostic for radiculopathy.

ii. In general, EMG and NCS are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electrodiagnostic studies may provide useful, correlative neuropathophysiological information that would be otherwise unobtainable from the radiologic studies discussed above.

iii. Portable Automated Electrodiagnostic Device (also known as Surface EMG) this is not a substitute for conventional diagnostic testing in clinical decision-making and therefore, is not recommended.

iv. Somatosensory Evoked Potential (SSEP) is useful for the evaluation of myelopathy. It is not recommended to identify radiculopathy.

v. Current Perception Threshold Evaluation (CPT) may be useful as a screening tool, but its diagnostic efficacy in the evaluation of cervical spine pain has not been determined. Therefore, CPT is not recommended as a diagnostic tool

b. Injections—Diagnostic

i. Description Diagnostic cervical injections are generally accepted well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy.

ii. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined

by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms. Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be primary pain generators. Patients should not receive all of the diagnostic blocks listed merely in an attempt to identify 100percent of the pain generators.

iii. The interpretation of the test results are primarily based on functional change, symptom report, and pain response (via a recognized pain scale before and at an appropriate time after the injection). The diagnostic significance of the test result should be evaluated in conjunction with clinical information and the results of other diagnostic procedures. Injections with local anesthetics of differing duration may be used to support a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose cervical conditions. Refer to Injections – Therapeutic for information on specific injections.

iv. It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure is evident to other reviewers. This entails, at a minimum, documentation of patient response immediately following the procedure with details of any symptoms with a response and the degree of response. Additionally, a log must be recorded as part of the medical records which documents response, if any, on an hourly basis for, at a minimum, the expected duration of local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., neck, arm pain). The practitioner must identify the local anesthetic used and the expected duration of response for diagnostic purposes.

v. Multiple injections provided at the same session without staging may seriously dilute the diagnostic value of these procedures. Practitioners must carefully weigh the diagnostic value of the procedure against the possible therapeutic value.

vi. Special Requirements for Diagnostic Injections. Since multi-planar fluoroscopy during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner should have completed fellowship training in pain medicine with interventional training, or its equivalent. They must also be knowledgeable in radiation safety.

vii. Complications. General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningial abscess. Severe complications are remote but can include spinal cord damage, quadriplegia, and/or death. Injections at a C2-C3 level frequently cause temporary neuritis with ataxia.

viii. Contraindications. Absolute contraindications to diagnostic injections include:

- (a). bacterial infection—systemic or localized to region of injection;
- (b). bleeding diatheses;
- (c). hematological conditions and

(d). possible pregnancy.

ix. Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus, and hypertension.

x. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

xi. Specific Diagnostic Injections. In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to “Injections – Therapeutic” for information on specific therapeutic injections.

(a). Medial branch blocks are generally-accepted diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy). The International Spine Intervention Society (ISIS) suggests controlled blocks – using either placebo or an anesthetic with a varying length of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block, the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases, this will mean a reduction of pain to 1 or 2 on the Visual Analog Scale (VAS) 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

(b). A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

(i). Frequency and Maximum Duration May be repeated once for comparative blocks. Limited to four levels / five medial branches.

c. Atlanto-Axial and Atlanto-Occipital injections are generally accepted for diagnosis and treatment but do not lend themselves to denervation techniques owing to variable neuroanatomy. Injection of this articulation is complicated by the proximity of the vertebral artery, which may be tortuous at the level of the C1 joint. Inadvertent injection of the vertebral artery may cause respiratory arrest, seizure, stroke, or permanent neurological sequelae. Only practitioners skilled in these injections should perform them.

i. Frequency and Maximum Duration: Once per side

d. Transforaminal injections / Spinal selective nerve root blocks are generally accepted and useful in identifying spinal pathology. When performed for diagnosis, small amounts of local anesthetic should be used to determine the level of nerve root irritation. A positive diagnostic block

should result in a positive diagnostic functional benefit and a 50 percent reduction in nerve-root generated pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS).

i. Time to Produce Effect: less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients.

ii. Frequency and Maximum Duration: once per suspected level, limited to two levels

e. Zygapophyseal (Facet) Blocks. Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks.

f. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to Therapeutic Spinal Injections.)

i. Time to Produce Effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients.

ii. Frequency and Maximum Duration: Once per suspected level, limited to two levels.

g. Personality/ Psychological/ Psychiatric/ Psychosocial Evaluation: These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

i. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- (a). employment history;
- (b). interpersonal relationships-both social and

work;

(c). patient activities;

(d). current perception of the medical system;

(e). current perception/attitudes toward employer/job

(f). results of current treatment

(g). risk factors and psychological comorbidities that may influence outcome and that may require treatment

(h). childhood history, including history of childhood psychological trauma, abuse and family history of disability.

ii. Personality / psychological / psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

iii. Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

h. Provocation Discography

i. Description. Discography is an accepted, but rarely indicated, invasive diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, preconditions, special considerations, procedures, reporting requirements, and results, are carefully and specifically followed. Results should be interpreted judiciously. Fewer studies have been published on cervical and thoracic discography than on lumbar discography.

ii. Indications. Discography may be indicated when a patient has a history of functionally limiting, unremitting cervical pain of greater than four months duration, with or without arm pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.

iii. Discography may prove useful for the evaluation of the pre-surgical spine, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.

iv. Discography may show disc degeneration and annular disruption in the absence of cervical pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential neck pain. Because patients with mild neck pain should not be considered for

invasive treatment, discography should not be performed on these patients. The presence of an annular tear does not necessarily identify the tear as a pain generator.

v. Discography is not useful in previously operated discs. Discography may prove useful in evaluating the number of cervical spine levels that might require fusion. CT Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

vi. Preconditions for provocation discography include all of the following:

(a). A patient with functionally limiting, unremitting neck and/or arm pain of greater than four months duration in whom conservative treatment has been unsuccessful and in whom the specific diagnosis of the pain generator has not been made apparent on the basis of other noninvasive imaging studies (e.g., MRI, CT, plain films, etc.). It is recommended that discography be reserved for use in patients with equivocal MRI findings, especially at levels adjacent to clearly pathological levels. Discography may be more sensitive than MRI or CT in detecting radial annular tears. However, radial tears must always be correlated with clinical presentation.

(b). Psychosocial evaluation has been completed. There is some evidence that false positives and complaints of long-term pain arising from the procedure itself occur more frequently in patients with somatoform disorders. Therefore, discograms should not be performed on patients with non-anatomic symptoms consistent with somatoform disorders.

(c). Patients who are considered surgical candidates (e.g., symptoms are of sufficient magnitude and the patient has been informed of the possible surgical options that may be available based upon the results of discography). Discography should never be the sole indication for surgery.

(d). Informed consent regarding the risks and potential diagnostic benefits of discography has been obtained.

vii. Complications include, but are not limited to, discitis, nerve damage, retropharyngeal abscess, chemical meningitis, pain exacerbation, and anaphylaxis. Therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

viii. Contraindications include: (a) active infection of any type or continuing antibiotic treatment for infection; and/or (b) bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or (c) significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or (d) presence of clinical myelopathy; and/or (e) effacement of the cord, thecal sac or circumferential absence of epidural fat; and (f) known allergic reactions.

ix. Special Considerations

(a). Discography should not be performed by the physician expected to perform the therapeutic procedure. The procedure should be carried out by an experienced individual who has received specialized training in the technique of provocation discography.

(b). Discography should be performed in a blinded format that avoids leading the patient with anticipated responses. The procedure should always include one or more disc levels thought to be normal or nonpainful in order to serve as an internal control. The patient should not know what level is being injected in order to avoid spurious results. Adjacent discs may be identified as pain generators in more than half of cases in which discogenic pain is identified at one level. Because surgery is likely to fail in multi-level discogenic pain, injection of as many levels as feasible can prevent many operative failures. Abnormal disc levels may be repeated to confirm concordance.

(c). Sterile technique must be utilized.

(d). Judicious use of light sedation during the procedure is acceptable, represents the most common practice nationally at the current time, and is recommended by most experts in the field. The patient must be awake and able to accurately report pain levels during the provocation portion of the procedure.

(e). CT or MRI should establish cervical spinal dimensions and ruled out spinal stenosis.

(f). Intradiscal injection of local anesthetic may be carried out after the provocation portion of the examination and the patient's response.

(g). It is recommended that a post-discogram CT be considered as it frequently provides additional useful information about disc morphology or other pathology.

x. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of disc morphology and the pain response. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

xi. When discography is performed to identify the source of a patient's neck pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

xii. Caution should be used when interpreting results from discography. One study using asymptomatic volunteers reported pain in the majority of discs injected, but no subjects reported pain exceeding 6/10 on a pain scale in a normal disc.

i. Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where

i. Grade 0 = Normal Nucleus.

ii. Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.

iii. Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.

iv. Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.

v. Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.

vi. Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

j. Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society Guidelines (ISIS). The report must include the level of concordance for neck and arm pain separately using a 10-point VAS, or similar quantitative assessment. It should be noted that the change in the VAS score before and after provocation is more important than the number reported.

k. The diagnosis of discogenic pain is less likely when there are more discs with dissimilar pain and fewer with no pain. At least two discs with no pain on stimulation and one disc with concordant pain registering at least 7 on a 10-point VAS or equivalent should be present to qualify for a diagnosis of discogenic pain. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

l. Time parameters for provocation discography are as follows:

i. Frequency: One time only.

ii. Maximum: Repeat Discography is rarely indicated

m. Thermography is an accepted and established procedure, but has no use as a diagnostic test for cervical pain. It may be used to diagnose regional pain disorders and in these cases, refer to the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. Special tests are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return-to-work, his/her strength capacities, and physical work demand classifications and tolerance. The procedures in this subsection are listed in alphabetical order, not by importance.

a. Computer-Enhanced Evaluations may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range-of-motion, endurance, or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment and demonstrated motivation. These evaluations should not be used alone to determine return-to-work restrictions.

i. Frequency: One time for evaluation. Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. Functional Capacity Evaluation (FCE): is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability, as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; non-material and material handling activities cognitive; visual; and sensory perceptual factors.

i. When an FCE is being used to determine return to a specific jobsite, the provider is responsible for fully understanding the job duties. A jobsite evaluation is frequently necessary. FCEs cannot be used in isolation to

determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

ii. Full FCEs are sometimes not necessary. If Partial FCEs are performed, it is recognized that all parts of the FCE that are not performed are considered normal. In many cases, a work tolerance screening will identify the ability to perform the necessary job tasks.

c. Frequency: Can be used initially to determine baseline status. Additional evaluations can be performed to monitor and assess progress and aid in determining the endpoint for treatment.

d. Job site evaluation is a comprehensive analysis of the physical, mental and sensory components of a specific job. These components may include, but are not limited to; postural tolerance (static and dynamic); aerobic requirements; range-of-motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; sensation; coordination; environmental requirements of a job; repetitiveness; and essential job functions.

i. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return-to-work.

ii. Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following.

(a). to determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

(b). to make recommendations for, and to assess the potential for ergonomic changes;

(c). to determine the essential demands of the job. To provide a detailed description of the physical and cognitive job requirements;

(d). to assist the patient in their return-to-work by educating them on how they may be able to do their job more safely and in a more bio-mechanically appropriate manner;

(e). to give detailed work/activity restrictions.

iii. Frequency: One time with additional visits as needed for follow-up per jobsite.

f. Vocational Assessment. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

i. Frequency: One time with additional visits as needed for follow-up

g. Work Tolerance Screening: is a determination of an individual's tolerance for performing a specific job based

on a job activity or task and may be used when a full Functional Capacity Evaluation is not indicated. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. Full job description should include a physical assessment of the job requirements

i. Frequency: One time for initial screen. May monitor improvements in strength every 3 to 4 weeks up to a total of 6 visits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2009. Therapeutic Procedures—Non-Operative**

A. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to "Return-to-Work" in this section for detailed information.

C. Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

D. Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms

E. Lastly, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. Home therapy is an important component of therapy and may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone.

G. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation, and there is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Acupuncture is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range-of-motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

b. Acupuncture with Electrical Stimulation: is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

c. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

i. Time to Produce Effect: three to six treatments

ii. Frequency: one to three times per week.

iii. Optimum Duration: one to two months.

iv. Maximum Duration: 14 treatments.

2. Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

a. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities and time frames.

3. Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised

experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

a. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is to normalize the physiology to the pre-injury status to the extent possible, and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

b. Indications for biofeedback include individuals who are suffering from musculoskeletal injury in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often used in conjunction with other treatment modalities.

- i. Time to Produce Effect: three to four sessions.
- ii. Frequency: one to two times per week.
- iii. Optimum Duration: five to six sessions.
- iv. Maximum Duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive functional gains.

#### 4. Injections—Therapeutic

a. Therapeutic Spinal Injections. Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, have been undertaken. Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology. Injections are invasive procedures that can cause catastrophic complications; thus clinical indications and contraindications should be closely adhered to. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active ROM, strength, and stability. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings

b. Special Considerations—for all injections (excluding trigger point and occipital nerve blocks) multi-planar fluoroscopy, during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, neurology or psychiatry.

The practitioner should have completed fellowship training in pain medicine with interventional training, or its equivalent. They must also be knowledgeable in radiation safety.

c. Complications. Appropriate medical disclosures with regard to potential complications should be provided to the patient as deemed appropriate by the treating physician.

d. Contraindications. Absolute contraindications to therapeutic injections include: (a) bacterial infection – systemic or localized to region of injection, (b) bleeding diatheses, (c) hematological conditions, and (d) possible pregnancy.

i. Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus and hypertension.

(a). Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to American Society of Regional Anesthesia for anticoagulation guidelines.

#### (b). Cervical Epidural Steroid Injection (ESI)

(i). Description. Cervical ESIs are injections of corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation in the acute or subacute phases of injury, restoring range-of-motion, and thereby, facilitating progress in more active treatment programs.

(ii). Needle placement. Multi-planar fluoroscopic imaging is required for all epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle placement.

(iii). Indications. Cervical ESIs are useful in patients with symptoms of cervical radicular pain syndromes. They have less defined usefulness in non-radicular pain. There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). In one study, 53percent of patients had 50 percent or greater relief of pain at 6 months with only 20percent having similar relief at 12 months. There is some evidence to suggest that epidural injections are not effective for cervical axial pain; however, it is an accepted intervention. Only patients who have 1) pain affected by activity and two) annular tears verified by appropriate imaging may have injections for axial pain.

(iv). There is some evidence in studies of the lumbar spine that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful outcome from ESIs. This may also apply to the cervical spine although there are currently no studies to verify this finding. MRI or CT scans are required prior to thoracic and cervical ESIs, to assure that adequate epidural space is present.

(c). Time to Produce Effect: Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80percent of patients and 72 hours to 2 weeks for 20percent of patients.

ii. Frequency: One or more divided levels can be injected in one session. Whether injections are repeated depends upon the patient's response to the previous

injection. Subsequent injections may occur after one to two weeks if there is a positive patient response. Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

(a). Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. If the first injection does not provide a diagnostic response with temporary and sustained pain relief (at least two to six weeks) substantiated by accepted pain scales (i.e., 50 percent pain reduction as measured by tools such as VAS), and improvement in function, similar injections should not be repeated.

(b). Optimal Duration: Usually one to three injection(s), over a period of six months depending upon each patient's response and functional gain.

(c). Maximum Duration: Two sessions consisting of up to three injections each may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

e. Zygapophyseal (Facet) Injection

i. Description. A generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. There is conflicting evidence to support long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

ii. Indications. Patients with pain 1) suspected to be facet in origin based on exam findings and 2) affecting activity; OR patients who have refused a rhizotomy; OR patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

iii. Facet injections may be repeated if they result in increased documented functional benefit for at least 4 to 6 weeks and at least a 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

(a). Time to Produce Effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

(b). Frequency: 1 injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be

repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

(c). Optimum Duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

(d). Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

f. Intradiscal Steroid Therapy: Intradiscal Steroid Therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic low back pain. There is no support for its use in the cervical spine and its use is not recommended.

g. Radio Frequency (RF) Medial Branch Neurotomy/ Facet Rhizotomy:

i. Description. A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radio-frequency is the method generally used.

ii. There is good evidence to support this procedure in the cervical spine but benefits beyond one year are not yet established. Radio-frequency medial branch neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe under fluoroscopic guidance is required since the maximum effective diameter of the device is a 5 x 8 millimeter oval. Permanent images should be recorded to verify placement of the device.

iii. Indications. Those patients with proven, significant, facetogenic pain. This procedure is not recommended for patients with multiple pain generators or involvement of more than three medial branch nerves.

iv. Individuals should have met the following indications: pain of well-documented facet origin, unresponsive to active and/or passive therapy, manual therapy, and in which a psychosocial screening has been performed (e.g., pain diagram, thorough psychosocial history, screening questionnaire). It is generally recommended that this procedure not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy).

v. All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks-using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases this will mean a reduction of pain to 1 or 2 on the VAS 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these

activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

vi. A separate comparative block may be performed on a different date to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

vii. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

viii. Post-Procedure Therapy. Active therapy. Implementation of a gentle reconditioning program within the first post-procedure week is recommended, barring complications. Instruction and participation in a long-term home-based program of ROM, cervical, scapular, and thoracic strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

ix. Requirements for repeat RF neurotomy (or additional level RF neurotomies). In some cases pain may recur [ISIS]. Successful rhizotomy usually provides from six to eighteen months of relief.

x. Before a repeat RF neurotomy is done, a confirmatory medial branch injection should be performed if the patient's pain pattern presents differently than in the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

#### h. Occipital Nerve Block

i. Description. Occipital nerve blocks are generally accepted injections used both diagnostically and therapeutically in the treatment of occipital neuralgia. The greater occipital nerve is the target.

ii. Indications. Diagnosis and treatment of occipital neuralgia/cephalgia. Peripheral block of the greater occipital nerve may be appropriate as initial treatment. It may be indicated in patients unresponsive to peripheral nerve block or those patients in need of additional diagnostic information.

iii. Complications. Bleeding, infection, neural injury. Post procedural ataxia is common and usually lasts 30 minutes post procedure. Because the occipital artery runs with the occipital nerve, inadvertent intravascular injection is a risk of this procedure and may lead to systemic toxicity and/or seizures.

(a). Time to Produce Effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(b). Optimal Duration: one to three sessions for each nerve

(c). Maximum Duration: Continue up to three injections if progressive symptomatic and functional improvement can be documented.

(e). Trigger Point Injections and Dry Needling Treatment

iv. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of dry needling or injection of local anesthetic with or without, corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local

and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

v. There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

vi. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

vii. Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six-week time frame.

viii. Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

(a). Time to Produce Effect: Local anesthetic 30 minutes; no anesthesia 24 to 48 hours

(b). Frequency: Weekly, suggest no more than four injection sites per session per week to avoid significant post-injection soreness

(c). Optimal Duration: four Weeks

(d). Maximum Duration: eight weeks.

Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

(f). Prolotherapy: also known as sclerotherapy consists of a series of injections of hypertonic dextrose, with or without glycerine and phenol, into the ligamentous structures of the neck. There is no evidence that Prolotherapy is effective in cervical pain. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, the use of Prolotherapy for cervical pain is not recommended.

(g). Epiduroscopy and Epidural Lysis of Adhesions: is not recommended in the cervical spine secondary to the potential for dural puncture, hematoma, and spinal cord injury.

5. Medications used in the treatment of cervical injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The following are listed in alphabetical order:

a. Acetaminophen: is an effective analgesic with antipyretic but not anti-inflammatory activity. Acetaminophen is generally well tolerated, causes little or no gastrointestinal irritation, and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations may contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed 2250 mg per 24-hour period from all sources, including narcotic-acetaminophen combination preparations. Higher doses may result in liver toxicity.

i. Optimum Duration: 7 to 10 days.

ii. Maximum Duration: Chronic use as indicated on a case-by-case basis. Use of this substance long-term for three days per week or greater may be associated with rebound pain upon cessation.

b. Muscle Relaxants: are appropriate for muscle spasm with pain. There is strong evidence that muscle relaxants are more effective than placebo for providing short-term pain relief in acute low back pain. Similar effects can be expected for cervical pain. When prescribing these agents, physicians must seriously consider side effects of drowsiness or dizziness, and the fact that benzodiazepines may be habit-forming.

i. Optimum Duration: one week.

ii. Maximum Duration: two weeks (or longer if used only at night)

c. Narcotics should be primarily reserved for the treatment of severe cervical pain. In mild-to-moderate cases of cervical pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

d. Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the narcotic prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.

i. Optimum Duration: three to seven days.

ii. Maximum Duration: two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to

Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management.

e. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advise that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, histamine 2 blockers, or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete blood count (CBC), and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

i. Non-selective Nonsteroidal Anti-Inflammatory Drugs

(a). Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

(i). Optimal Duration: one week

(ii). Maximum Duration: one year Use of these substances long-term for (three days per week or greater) is associated with rebound pain upon cessation.

ii. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors

(a). Selective cyclo-oxygenase-2 (COX-2) inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency, thus renal function may need monitoring.

(b). COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur

even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

(i). Optimal Duration: 7 to 10 days

(ii). Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (for three days per week or greater) is associated with rebound pain upon cessation.

f. Oral Steroids: have limited use but are accepted in cases requiring potent anti-inflammatory drug effect and should not be routinely recommended.

g. Intravenous Steroids: The risks of permanent neurological damage from acute spinal cord compression generally outweigh the risks of pharmacologic side effects of steroids in an emergent situation.

h. Psychotropic/Anti-anxiety/Hypnotic Agents: may be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Antidepressant medications, such as tricyclics and Selective Serotonin Reuptake Inhibitors (SSRIs), are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low dose, are useful for chronic pain but have more frequent side effects.

i. Anti-anxiety medications should generally be limited to short-term use. Combinations of the above agents may be useful.

ii. As a general rule, providers (physicians or medical psychologist) should access the patient's prior history of substance abuse or depression prior to prescribing any of these agents. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not routinely recommended. Refer to the Chronic Pain Guidelines which give a detailed discussion regarding medication use in chronic pain management.

(a). Optimum Duration: one to six months.

(b). Maximum Duration: 6 to 12 months, with monitoring.

i. Tramadol: is useful in relief of pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Although Tramadol may cause impaired alertness, it is generally well tolerated, does not cause gastrointestinal ulceration, or exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, SSRIs, and tricyclic antidepressants. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation and is not recommended for those with prior opioid addiction.

i. Optimal Duration: three to seven days

ii. Maximum Duration: two weeks. Use beyond two weeks is acceptable in appropriate cases.

## 6. Occupational Rehabilitation Programs

a. Non-Interdisciplinary. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuro-musculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions),

patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to active treatment and/or simulated/real work.

### i. Work Conditioning

(a). These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(i). Length of Visit: one to two hours per day

(ii). Frequency: two to five visits per week

(iii). Optimum Duration: two to four weeks

(iv). Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

### ii. Work Simulation

(a). Work simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

(i). Length of Visit: two to six hours per day

(ii). Frequency: two to five visits per week

(iii). Optimum Duration: two to four weeks

(iv). Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

b. Interdisciplinary—programs are well-established treatment for patients with sub-acute and functionally impairing cervical spine pain. They are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured workers program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. Programs should include cognitive-behavioral therapy as there is good evidence for its effectiveness in patients with chronic low back pain and it is probably effective in cervical spine pain. These programs are for patients with greater levels of disability, dysfunction, deconditioning and psychological involvement. For patients with chronic pain, refer to the Chronic Pain Disorder Medical Treatment Guidelines.

### i. Work Hardening

(a). Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological,

behavioral, physical, functional, and vocational components of employability and return-to-work.

(b). This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; occupational therapy; physical therapy; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, vocational specialist or Certified Biofeedback Therapist.

- (i). Length of Visit: up to eight hours/day
- (ii). Frequency: two to five visits per week
- (iii). Optimal Duration: two to four weeks
- (iv). Maximum Duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

#### ii. Spinal Cord Programs

(a). Spinal Cord Systems of Care provide coordinated, case-managed, and integrated service for people with spinal cord dysfunction, whether due to trauma or disease. The system includes an inpatient component in an organization licensed as a hospital and an outpatient component. Each component endorses the active participation and choice of the persons served throughout the entire program. The Spinal Cord System of Care also provides or formally links with key components of care that address the lifelong needs of the persons served.

(b). This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified and trained in rehabilitation, a case manager, occupational therapy, physical therapy, psychologist, rehabilitation RN and MD, and therapeutic recreation specialist. As appropriate, the team may also include: rehabilitation counselor, respiratory therapist, social worker, or speech-language pathologist.

(c). Timeframe durations for any spinal cord program should be determined based upon the extent of the patient's injury and at the discretion of the rehabilitation physician in charge.

7. Orthotics. Primary principles and objectives of the application of cervical orthosis include, control of the position through the use of control forces; application of corrective forces to abnormal curvatures; aid in spinal stability when soft tissues or osteoligamentous structures cannot sufficiently perform their role as spinal stabilizers; and restrict spinal segment movement after acute trauma or surgical procedure. In cases of traumatic cervical injury, the most important objective is the protection of the spinal cord and nerve root.

#### a. Cervical Collars

i. Soft Collars are well-tolerated by most patients but may not significantly restrict motion in any plane and are associated with delayed recovery. There is no evidence that their use promotes recovery from cervical sprain. In acute strain/sprain type injuries, use of cervical collars may prolong disability, limit early mobilization, promote

psychological dependence, and limit self-activity. There is some evidence that patients encouraged to continue usual activity have less neck stiffness and headache than patients placed in cervical collars following motor vehicle crashes.

ii. Rigid Collars, such as a Philadelphia Orthosis, are useful post-operative or in emergency situations. These collars restrict flexion and extension motion, and to a lesser degree, lateral bending and rotation. Duration of wear post-surgery is dependent upon the surgeon and degree of cervical healing but is generally not used beyond eight weeks.

b. Poster Appliances: such as the Miami brace, restrict flexion and extension motion to about the same degree as a Philadelphia collar, and to a greater degree, lateral bending and rotation. Not recommended in sprain or strain injuries.

c. Cervicothoracic Orthosis: such as Yale and sternal occipital mandibular immobilization (SOMI) type braces, restrict flexion and extension motion to a fuller degree than the Philadelphia collar and to a better degree lateral bending and rotation. Not recommended in sprain or strain type injuries.

d. Halo Devices: are used in the treatment of cervical fracture, dislocation, and instability at the discretion of the treating surgeon. Refer to Halo Devices in the Operative Treatment section.

e. Other Orthosis Devices and Equipment: Special orthosis or equipment may have a role in the rehabilitation of a cervical injury such as those injuries to a cervical nerve root resulting in upper extremity weakness or a spinal cord injury with some degree of paraparesis or tetraparesis. Use of such devices would be in a structured rehabilitation setting as part of a comprehensive rehabilitation program.

8. Patient education. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as, facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed.

a. Time to Produce Effect: Varies with individual patient

b. Frequency: Should occur at each visit

9. Personality/psychological/psychiatric/ psychosocial intervention is a generally accepted, widely used, and well-established intervention. This group of therapeutic and diagnostic modalities includes, but is not limited to; individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis and meditation. Any evaluation or diagnostic workup should clarify and distinguish between pre-existing versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. This can be used alone or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the Chronic Pain Disorder Medical Treatment Guidelines.

a. Time to Produce Effect: two to four weeks  
b. Frequency: one to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly.

c. Optimum Duration: six weeks to three months

d. Maximum Duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required, and if further counseling beyond three months is indicated, extensive documentation addressing which pertinent issues are preexisting versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating practitioner every four to six weeks during treatment.

10. Restriction of activities. There is some evidence to support the continuation of normal daily activities as the recommended treatment for acute and chronic cervical injuries without neurologic symptoms. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with cervical spine injuries.

11. Return-to-work: Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months. It is imperative that the patient be educated regarding the benefits of return-to-work, restrictions, and follow-up if problems arise. When attempting to return a patient to work after a specific injury, clear objective restrictions of activity level should be made. An accurate job description with detailed physical duty descriptions is often necessary to assist the physician in making return-to-work recommendations. This may require a jobsite evaluation.

a. Employers should be prepared to offer transitional work. This may consist of temporary work in a less demanding position, return to the regular job with restrictions, or gradual return to the regular job. Company policies which encourage return-to-work with positive communication are most likely to have decreased worker disability.

b. Return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Due to the large spectrum of injuries of varying severity and varying physical demands in the work place, it is not possible to make specific return-to-work guidelines for each injury. Therefore, the OWCA recommends the following.

i. Establishment of a Return-To-Work Status: Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan, and addressed at every visit. A description of daily activity limitations is part of any treatment plan and should be the basis for restriction of work activities. In most non-surgical cases, the patient should be able to return to work in some capacity or in an alternate position consistent with medical treatment within several days unless there are extenuating circumstances. Injuries requiring more than two weeks off work should be thoroughly documented.

ii. Establishment of Activity Level Restrictions: Communication is essential between the patient, employer, and provider to determine appropriate restrictions and return-to-work dates. It is the responsibility of the physician to provide clear concise restrictions, and it is the employer's responsibility to determine if temporary duties can be provided within the restrictions. For cervical spine injuries, the following should be addressed when describing the patient's activity level:

(a). Total body position including upper trunk, especially rotation and flexion. To include duration and frequency.

(b). Upper extremity requirements including reaching above the shoulder, repetitive motions, pushing, pulling, and lifting or carrying requirements. Duration and frequency should be included.

(c). Sitting duration and frequency with regard to posture, work height(s), and movements of the head and neck.

(d). Visual field requirements in respect to limitations in head and neck movements and tolerance to looking upward and downward.

(e). Use of adaptive devices or equipment for proper office ergonomics or to enhance capacities can be included.

iii. Compliance with Activity Restrictions: In some cases, compliance with restriction of activity levels may require a complete jobsite evaluation, a functional capacity evaluation (FCE), or other special testing. Refer to the "Special Tests" section of this guideline.

12. Therapy—Active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. They are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range-of-motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

b. The following active therapies are listed in alphabetical order:

c. Activities of Daily Living (ADL):: are well-established interventions which involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

i. Time to Produce Effect: four to five treatments

ii. Frequency: three to five times per week

iii. Optimum Duration: four to six weeks

iv. Maximum Duration: six weeks

d. Aquatic Therapy: is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, range-of-motion, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

- i. Cannot tolerate active land-based or full-weight bearing therapeutic procedures;
- ii. Require increased support in the presence of proprioceptive deficit;
- iii. Are at risk of compression fracture due to decreased bone density;
- iv. Have symptoms that are exacerbated in a dry environment;
- v. Would have a higher probability of meeting active therapeutic goals than in a dry environment.
- vi. The pool should be large enough to allow full extremity range-of-motion and fully erect posture. Aquatic vests, belts, and other devices may be used to provide stability, balance, buoyancy, and resistance.

(a). Time to Produce Effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum Duration: four to six weeks

(d). Maximum Duration: eight weeks

(e). A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a self-directed dry environment exercise program.

(f). Functional Activities: are well-established interventions which involve the use of therapeutic activities to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(i). Time to Produce Effect: four to five treatments

(ii). Frequency: three to five times per week

(iii). Optimum Duration: four to six weeks

(iv). Maximum Duration: six weeks

(g). Functional Electrical Stimulation: is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy due to radiculopathy.

(i). Time to Produce Effect: two to six treatments

(ii). Frequency: three times per week

(iii). Optimum Duration: eight weeks

(iv). Maximum Duration: eight weeks. If beneficial, provide with home unit.

(h). Neuromuscular Re-education: is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength, movement patterns, neuromuscular response, proprioception, kinesthetic sense, and coordination, education of movement, balance, and posture. Indications

include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(i). Time to Produce Effect: two to six treatments

(ii). Frequency: three times per week

(iii). Optimum Duration: four to eight weeks

(iv). Maximum Duration: eight weeks

(i). Spinal Stabilization: is a generally accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(i). Time to Produce Effect: four to eight treatments

(ii). Frequency: three to five times per week

(iii). Optimum Duration: four to eight weeks

(iv). Maximum Duration: eight weeks

(j). Therapeutic Exercise: is a generally well-accepted treatment. Therapeutic exercise with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception and coordination, increased range-of-motion and are used to promote normal movement patterns. Therapeutic exercise can also include complementary/alternative exercise movement therapy (with oversight of a physician or appropriate healthcare professional).

(i). Time to Produce Effect: two to six treatments

(ii). Frequency: three to five times per week

(iii). Optimum Duration: four to eight weeks

(iv). Maximum Duration: eight weeks

13. Therapy—Passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies such as postural stabilization and exercise programs to help control swelling, pain, and inflammation during the active rehabilitation process. Please refer to General Guideline Principles, Active Interventions. Passive therapies may be used intermittently as a therapist deems appropriate or regularly if there are specific goals

with objectively measured functional improvements during treatment.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum". Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" has been completed alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

i. The following passive therapies are listed in alphabetical order:

(a). Electrical Stimulation (Unattended): is an accepted treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation. A home unit should be purchased if treatment is effective and frequent use is recommended.

(i). Time to Produce Effect: two to four treatments

(ii). Frequency: Varies, depending upon indication, between two to three times/day to 1 time/week. A home unit should be purchased if treatment is effective and frequent use is recommended.

(iii). Optimum Duration: four treatments for clinic use

(iv). Maximum Duration: eight treatments for clinic use

(b). Iontophoresis: is an accepted treatment which consists of the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, salicylate), ischemia (magnesium, mecholy, iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars, and keloids (sodium chloride, iodine, acetate). There is no proven benefit for this therapy in the cervical spine.

(i). Time to Produce Effect: one to four treatments

(ii). Frequency: 3 times per week with at least 48 hours between treatments

(iii). Optimum Duration: four to six weeks

(iv). Maximum Duration: six weeks

(c). Manipulation: is a generally accepted, well-established, and widely used therapeutic intervention for cervical pain. Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(i). High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment.

This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as a) direct- a forceful engagement of a restrictive/pathologic barrier, b) indirect- a gentle/non-forceful dis-engagement of a restrictive/pathologic barrier, c) the patient actively assisting in the treatment and d) the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

(ii). High velocity, low amplitude (HVLA) manipulation is performed by taking a joint to its end range of motion and moving the articulation into the zone of accessory joint movement, well within the limits of anatomical integrity. There is good scientific evidence to suggest that HVLA manipulation can be effective for relieving pain and decreasing muscle spasm to improve function for patients with cervical pain. There is some evidence to show that manipulation of the cervical spine with exercise may be effective prophylactic treatment for cervicogenic headaches. Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebrobasilar insufficiency, or carotid artery disease. Relative contraindications include stenosis, spondylosis, and disc herniation.

b. Manipulation / Grade I - V

i. Time to produce effect for all types of manipulative treatment: one to six treatments.

ii. Frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks. For further treatments, twice per week or less to maintain function.

iii. Optimum Duration: 8 to 12 weeks

iv. Maximum Duration: three months. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Refer to the Chronic Pain Guidelines for care beyond three months.

c. Manipulation under General Anesthesia (MUA) refers to manual manipulation of the cervical spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for its use. There have been no high quality studies to justify MUAs benefits. Given the risks of general anesthetic and conscious sedation, it is not recommended.

d. Manipulation under Joint Anesthesia (MUJA) refers to manipulation of the cervical spine in combination with a fluoroscopically guided injection of anesthetic with or

without corticosteroid agents into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

e. **Massage. Manual or Mechanical.** Massage is a generally well-accepted treatment consisting of manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range-of-motion, or to increase muscle relaxation and flexibility prior to exercise.

i. As with all passive therapies, massage must be accompanied by exercise and patient education.

ii. **Mobilization—Grade I - V**

(a). Time to Produce Effect: Immediate

(b). Frequency: one to two times per week

(c). Optimum Duration: six weeks

(d). Maximum Duration: two months

f. **Mobilization (Joint)** is a generally well-accepted treatment consisting of passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. For further discussion on Level V joint mobilization please see section on HVLA manipulation [Section 12. c.]. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy. For Level V mobilization, contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebrasilar insufficiency, or carotid artery disease. Relative contraindications include stenosis, spondylosis, and disc herniation.

i. Time to Produce Effect: six to nine treatments

ii. Frequency: Up to three times per week

iii. Optimum Duration: four to six weeks

iv. Maximum Duration: six weeks

g. **Mobilization (Soft Tissue):** is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and other manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

i. Time to Produce Effect: four to nine treatments

ii. Frequency: Up to three times per week

iii. Optimum Duration: four to six weeks

iv. Maximum Duration: six weeks

h. **Short-Wave Diathermy** is an accepted treatment which involves the use of equipment that exposes soft tissue

to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced reabsorption of hemorrhage/hematoma or edema.

i. Time to Produce Effect: two to four treatments

ii. Frequency: two to three times per week up to three weeks

iii. Optimum Duration: three to five weeks

iv. Maximum Duration: five weeks

i. **Superficial Heat and Cold Therapy (Excluding Infrared Therapy):** is a generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

i. Time to Produce Effect: Immediate

ii. Frequency: two to five times per week

iii. Optimum Duration: three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months

iv. Maximum Duration: two months

j. **Traction-Manual—**is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation.

i. Time to Produce Effect: one to three sessions

ii. Frequency: two to three times per week

iii. Optimum Duration: 30 days

iv. Maximum Duration: one month

k. **Traction. Mechanical:** is a generally accepted treatment and most commonly used for patients with radicular findings. It is sometimes used to treat symptoms from decreased joint space and muscle spasm around the joints. If successful it should be shifted to home traction. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home cervical traction unit may be purchased if therapy proves effective.

i. Time to Produce Effect: 1 to 3 sessions up to 30 minutes. If response is negative after 3 treatments, discontinue this modality

ii. Frequency: two to three times per week. A home cervical traction unit may be purchased if therapy proves effective.

iii. Optimum Duration: four weeks

iv. Maximum Duration: four weeks

l. **Transcutaneous Electrical Nerve Stimulation (TENS)** is a generally accepted treatment which should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width

and amplitude modulation. Consistent, measurable, functional improvement must be documented prior to the purchase of a home unit.

- i. Time to Produce Effect: Immediate
- ii. Frequency: Variable
- iii. Optimum Duration: three sessions
- iv. Maximum Duration: three sessions. Purchase or provide with home unit if effective.

m. Ultrasound (Including Phonophoresis) is an accepted treatment which uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation.

i. Phonophoresis is the transfer of medication through the use of sonic generators to the target tissue to control inflammation and pain. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

- (a). Time to Produce Effect: 6 to 15 treatments
- (b). Frequency: three times per week
- (c). Optimum Duration: four to eight weeks
- (d). Maximum Duration: eight weeks

14. Vocational Rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification highest functional level, motivation, and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation.

a. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

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### **§2011. Therapeutic Procedures—Operative**

A. All operative interventions should be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests. A comprehensive assimilation of these factors should have led to a specific diagnosis with positive identification of the pathologic condition(s). It is imperative for the clinician to rule out non-physiologic modifiers of pain presentation, or non-operative conditions mimicking radiculopathy or instability (peripheral compressive neuropathy, chronic soft tissue injuries, and psychological conditions), prior to consideration of elective surgical intervention. Early intervention may be required in acute incapacitating pain or in the presence of progressive neurological deficits. Patients who are not candidates for or refuse surgical treatment should be treated with non-operative therapy as indicated.

B. Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural

history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuromusculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques, or may be refractory to surgical intervention.

C. In situations requiring the possible need for re-surgery, a second opinion may be necessary. Psychological evaluation is strongly encouraged when surgery is being performed for isolated axial pain to determine if the patient will likely benefit from the treatment.

D. Interdisciplinary interventions should be strongly considered post-operatively in patients not making functional progress within expected time frames (Refer to Interdisciplinary Programs).

E. Return to work activity restrictions should be specific according to the recommendations in Return to Work. Most cervical non-fusion surgical patients can return to a limited level of duty between three to six weeks. Full activity is generally achieved between six weeks to six months, depending on the procedure and healing of the individual.

1. Acute fractures and dislocations: Decisions regarding the need for surgery in acute traumatic injury will depend on the specific injury type and possibility of long-term neurologic damage. Acute disc herniations may occur in the presence of traumatic injury.

#### a. Halo Immobilization

i. Description. Intervention that restricts flexion-extension motion. Halo vest will provide significant but not complete rotational control and is the most effective device for treating unstable injuries to the cervical spine.

ii. Complications. May include pin infection, pin loosening, and palsy of the sixth cranial nerve.

iii. Surgical Indications. Cervical fractures requiring the need for nearly complete restriction of rotational control, and to prevent graft dislodgment, spine mal-alignment, or pseudarthrosis. Decision for use of halo is at the discretion of the surgeon based upon the patients' specific injury. Not indicated for unstable skull fractures or if skin overlying pin sites is traumatized.

iv. Operative Treatment. Placement of the pins and apparatus.

v. Post-Operative Therapy. Traction may be required for re-alignment and or fracture reduction (amount to be determined by surgeon), active and/or passive therapy, pin care.

#### b. Anterior or Posterior Decompression with Fusion

i. Description—to provide relief of pressure on the cervical spinal cord and nerve roots, and alignment and stabilization of the spine. May involve the use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae.

ii. Complications—appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

iii. Surgical Indications—when a significant or progressive neurological deficit exists in the presence of spinal canal compromise. Whether early decompression and reduction of neural structures enhances neurological recovery continues to be debated. Currently, a reasonable approach would be to treat non-progressive neurological

deficits on a semi-urgent basis, when the patient's systemic condition is medically stable.

iv. Operative Treatment—both anterior and posterior surgical decompression of the cervical spine are widely accepted. The approach is guided by location of the compressive pathology as well as the presence of other concomitant injuries. Posterior stabilization and fusion alone may be indicated for patients who have been realigned with traction and do not have significant canal compromise. The anterior approach is acceptable if there is disc and/or vertebral body anteriorly compromising the canal. The posterior approach may be indicated in radiculopathy in the absence of myelopathy and with evidence of pseudarthrosis on radiographs, or if the compression pathology is arising posteriorly.

(a). The number of levels involved in the fracture pattern determines the choice between the use of wire techniques versus spinal plates. In injuries treated with an anterior decompression procedure, anterior bone grafting alone does not provide immediate internal fixation and an anterior cervical plate is significantly beneficial. Patients who undergo surgery for significant fracture dislocations of the spine (three level injury) with canal compromise are best managed with anterior cervical decompression, fusion, and plating but in some cases posterior stabilization and fusion are also considered.

(b). Recombinant Human Bone Morphogenetic Protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. BMP usage in the anterior cervical spine is generally not indicated.

v. Post-Operative Treatment. Cervical bracing may be appropriate (usually 6-12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening, and restoration of ROM, is appropriate once the fusion is solid and without complication. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

2. Disc herniation and other cervical conditions. Operative treatment is indicated only when the natural history of an operatively treatable problem is better than the natural history of the problem without operative treatment. All patients being considered for surgical intervention should undergo a comprehensive neuromuscular examination to identify pain generators that may respond to nonsurgical techniques or may be refractory to surgical intervention. Timely decision making for operative intervention is critical to avoid deconditioning, and increased disability of the cervical spine.

a. General Recommendations. There is some evidence to suggest that recovery from cervical radiculopathy in patients without clinical signs of spinal cord

compression at one year is similar with one-level fusion, physical therapy, or rigid cervical collar use. For patients with whiplash injury (Quebec Classification Grade Levels I or II), there is no evidence of any beneficial effect of operative treatment. Refer to (Soft Tissue Injury Evaluation), for Discussion on Quebec Classification Levels.

b. If cervical fusion is being considered, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the time of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

c. General Indications for Surgery. Operative intervention should be considered and a consultation obtained when improvement of symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of six weeks of treatment, or at the end of longer duration of non-operative intervention for debilitated patients with complex problems. Choice of hardware instrumentation is based on anatomy, the patient's pathology, and surgeon's experience and preference.

i. Specific Indications include

(a). for Patients with Myelopathy immediate surgical evaluation and treatment is indicated;

(b). for Patients with Cervical Radiculopathy.

(i). early intervention may be required for acute incapacitating pain or in the presence of progressive neurological deficits;

(ii). persistent or recurrent arm pain with functional limitations, unresponsive to conservative treatment after six weeks; or

(iii). progressive functional neurological deficit; or

(iv). static neurological deficit associated with significant radicular pain; and

(v). confirmatory imaging studies consistent with clinical findings.

(c). For Patients with Persistent Non-radicular Cervical Pain—in the absence of a radiculopathy, it is recommended that a decisive commitment to surgical or nonsurgical interventions be made within four to five months following injury. The effectiveness of three-level cervical fusion for non-radicular pain has not been established. In patients with non-radicular cervical pain for whom fusion is being considered, required pre-operative indications include all of the following.

(i). In general, if the program of non-operative treatment fails, operative treatment is indicated when:

[a]. improvement of the symptoms has plateaued, and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or

[b]. frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence;

[c]. mere passage of time with poorly guided treatment is not considered an active treatment program;

- (ii). all pain generators are adequately defined and treated; and
- (iii). all physical medicine and manual therapy interventions are completed; and
- (iv). x-ray, MRI, or CT/discography demonstrating disc pathology or spinal instability; and
- (v). spine pathology limited to two levels; and

(vi). psychosocial evaluation for confounding issues addressed;

(vii). for any potential surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

ii. Surgical Procedures include

(a). Cervical Discectomy with or without Fusion

(i). Description. Procedure to relieve pressure on one or more nerve roots or spinal cord. It may be performed with or without the use of a microscope.

(ii). Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

(iii). Surgical Indications. Radiculopathy from ruptured disc or spondylosis, spinal instability, or patients with non-radicular neck pain meeting fusion criteria. There is no evidence that discectomy with fusion versus discectomy without fusion has superior long-term results. Discectomy alone is generally considered in patients with pure radicular symptoms from their herniated disc and who have sufficiently large foramen that disc space collapse is unlikely to further compromise the nerve root. Failure rates increase with disease at more than two levels.

(iv). Operative Treatment. Cervical plating may be used to prevent graft dislodgment especially for multi-level disease.

(a). Recombinant Human Bone Morphogenetic Protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. Use of rhBMP-2 in the cervical spine may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures and on the esophagus. BMP usage in the anterior cervical spine is generally not indicated.

(v). Post-Operative Therapy. Cervical bracing may be appropriate (usually 6 - 12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program, with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate, once fusion is solid and without complication. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(b). Cervical Corpectomy

(i). Description. Removal of a portion or the entire vertebral body from the front of the spine. May also include removal of the adjacent discs. Usually involves fusion.

(ii). Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

(iii). Surgical Indications. Single or two-level spinal stenosis, spondylolisthesis, or severe kyphosis, with cord compression.

(iv). Operative Treatment. Neural decompression, fusion with instrumentation, or halo vest placement to maintain cervical position. Hemisectomy may be done when only a portion of the vertebral body needs to be resected. Allografts may be used for single bone graft fusion; however, autografts are generally preferable for multi-level fusions unless a large strut graft is required.

(v). Post-Operative Therapy — Dependent upon number of vertebral bodies involved, healing time may be longer than discectomy. Halo vest care is required. Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening is appropriate for most patients once the cervical spine is deemed stable and without complication. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(c). Cervical Laminectomy with or without Foraminotomy or Fusion:

(i). Description. Surgical removal of the posterior portion of a vertebrae in order to gain access to the spinal cord or nerve roots with or without stabilization fusion. /instrumentation.

(ii). Complications. May include perineural fibrosis, kyphosis in fractures without fusion or with failed fusion, nerve injury, post surgical instability (with foraminotomies), CSF leak, infection, in-hospital mortality, non-union of fusion, donor site pain (autograft only).

(iii). Surgical Indications. Neural compression.

(iv). Operative Treatment. Laminotomy, partial discectomy, and nerve root decompression.

(v). Post-Operative Therapy. Cervical bracing may be appropriate (usually 6 to 12 weeks with fusion). Home programs with instruction in ADLs, sitting, posture, and a daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate for most patients once the cervical spine is deemed stable and without complication. The goals of the therapy program should include instruction in a long-term home-based exercise program. (Refer to Active Therapy).

(d). Cervical Laminoplasty

(i). Description. Technique that increases anterior or posterior dimensions of the spinal canal while

leaving posterior elements partially intact. It may be performed with or without the use of a microscope.

(ii). Complications. Loss of cervical motion, especially extension.

(iii). Surgical Indications. Multi-level disease: cervical spinal stenosis or spondylitic myelopathy. Not indicated in cervical kyphosis.

(iv). Operative Treatment. Posterior approach, with or without instrumentation.

(v). Post-Operative Therapy. May include 4 to 12 weeks of cervical bracing. Home programs with instruction in ADLs, sitting, posture, and daily walking program should be an early part of the rehabilitation process. Referral to a formal rehabilitation program with emphasis on cervical, scapular, and thoracic strengthening and restoration of ROM is appropriate once the cervical spine is stable and without complication. Active treatment which patients should have had prior to surgery will frequently require a repeat of the sessions previously ordered. The goals of the therapy program should include instruction in a long-term, home-based exercise program. (Refer to Active Therapy).

(e). Percutaneous Discectomy:

(i). Description. An invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control.

(ii). Complications include, but are not limited to, injuries to the nerve or vessel, infection, and hematoma.

(iii). Surgical Indications. Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long-term improvement.

(iv). Operative Treatment—partial discectomy

3. Artificial cervical disc replacement involves the insertion of an FDA approved prosthetic device into the cervical intervertebral space with the goal of maintaining physiologic motion at the treated cervical segment. The use of artificial discs in motion-preserving technology should be based on the surgeon's skill and training.

4. Percutaneous radiofrequency disc decompression of the cervical spine is an investigational procedure which introduces a 19 gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of a contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. There have been no randomized clinical trials of this procedure at this time. It is not recommended.

5. Epiduroscopy and epidural lysis of adhesions. Refer to Therapeutic Injections.

6. Intraoperative monitoring is a common intraoperative electrodiagnostic technique that may include somatosensory evoked potentials (SSEP), motor evoked potentials (MEP), or pedicle screw monitoring. The monitoring procedure may be used at the discretion of the surgeon. The use of intraoperative monitoring can be anticipated to become more common as percutaneous spinal procedures gain greater acceptance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2012. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:  
OWCA—Medical Services  
ATTN: Medical Director  
P.O. Box 94040  
Baton Rouge, LA 70804

- 1. Social Security No. \_\_\_ - \_\_\_ - \_\_\_
- 2. Date of Injury/Illness \_\_\_ - \_\_\_ - \_\_\_
- 3. Parts of Body Injury \_\_\_\_\_
- 4. Date of Birth \_\_\_ - \_\_\_ - \_\_\_
- 5. Date of This Request \_\_\_ - \_\_\_ - \_\_\_
- 6. Claim Number \_\_\_\_\_

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by  
\_\_\_ Employee \_\_\_ Employer \_\_\_ Insurer \_\_\_ Health Care Provider \_\_\_  
Other \_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.

**EMPLOYEE**

8. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

**EMPLOYEE'S ATTORNEY**

9. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER**

10. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**INSURER/ADMINISTRATOR**

(circle one)  
11. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER/INSURER'S ATTORNEY**

12. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**TREATING/REQUESTING PHYSICIAN**

13. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

LWC-WC 1009  
11/2010

14. PLEASE PROVIDE A SUMMARY OF THE DETAILS REGARDING THE ISSUE AT DISPUTE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You may attach a letter or petition with additional information with this disputed claim.  
The information given above is true and correct to the best of my knowledge and belief.

SIGNATURE OF REQUESTING PARTY \_\_\_\_\_ DATE \_\_\_\_\_

LWC-WC 1009  
11/2010

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

## **Chapter 20. Low Back Pain**

### **§2013. Introduction**

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation (OWCA) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana Workers' Compensation Act as injured workers with low back pain. The guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2015. General Guideline Principles**

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer, and patient through the Office of Workers Compensation.

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of low back pain. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an

effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. Treatment Parameter Duration—time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

4. Active Interventions—emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation Treatment Every Three to Four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move

patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return-to-Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply.

a. *Consensus* means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. *Some* means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. *Good* means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. *Strong* means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases,

regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2017. Initial Diagnostic Procedures

A. The OWCA recommends the following diagnostic procedures be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures, that should be utilized when initially diagnosing a work-related low back pain complaint, are listed below.

1. History-taking and physical examination (Hx and PE) are generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictates subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not complementing each other, the objective clinical findings should have preference. The medical records should reasonably document the following.

a. History of Present Injury—a detailed history, taken in temporal proximity to the time of injury should primarily guide evaluation and treatment. The history should include pertinent positive and negative information regarding the following:

i. mechanism of injury. This includes details of symptom onset and progression. The mechanism of injury should include a detailed description of the incident and the position of the body before, during, and at the end of the incident. Inclusion of normal work body postures, frequency during the workday, and lifting/push/pull requirements should be included in the absence of a known specific incident;

ii. location of pain, nature of symptoms, and alleviating/exacerbating factors (e.g., sitting tolerance). The history should include both the primary and secondary complaints (e.g., primary low back pain, secondary hip, groin). The use of a patient completed pain drawing, Visual Analog Scale (VAS), is highly recommended, especially during the first two weeks following injury to assure that all work related symptoms are addressed;

iii. presence and distribution of lower extremity numbness, paresthesias, or weakness, especially if precipitated by coughing or sneezing;

iv. alteration in bowel, bladder, or sexual function; and for female patients, alteration in their menstrual cycle;

v. prior occupational and non-occupational injuries to the same area including specific prior treatment, chronic or recurrent symptoms, and any functional limitations; Specific history regarding prior motor vehicle accidents may be helpful; and

vi. ability to perform job duties and activities of daily living.

b. Past History—

i. past medical includes neoplasm, gout, arthritis, hypertension, kidney stones, and diabetes;

ii. review of systems includes symptoms of rheumatologic, neurologic, endocrine, neoplastic, infectious, and other systemic diseases;

iii. smoking history;

iv. vocational and recreational pursuits; and

v. history of depression, anxiety, or other psychiatric illness.

c. Physical Examination—should include accepted tests and exam techniques applicable to the area being examined, including:

i. general inspection, including stance and gait;

ii. visual inspection;

iii. palpation;

iv. lumbar range of motion, quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may be indicated;

v. examination of thoracic spine and pelvis;

vi. nerve tension testing;

vii. sensory and motor examination of the lower extremities with specific nerve root focus;

viii. deep tendon reflexes with or without Babinski's;

ix. if applicable to injury, anal sphincter tone and/or perianal sensation; and

x. if applicable, abdominal examination, vascular examination, circumferential lower extremity measurements, or evaluation of hip or other lower extremity abnormalities;

xi. If applicable, Waddell Signs, which include five categories of clinical signs: tenderness; superficial and non-anatomic, pain with simulation: axial loading and rotation; regional findings: sensory and motor, inconsistent with nerve root patterns; distraction/inconsistency in straight leg raising findings, and over-reaction to physical examination maneuvers. Significance may be attached to positive findings in three out of five of these categories, but not to isolated findings. Waddell advocates considering Waddell's signs prior to recommending a surgical procedure. These signs should be measured routinely to identify patients requiring further assessment (i.e., biopsychosocial) prior to undergoing back surgery.

(a). It is generally agreed that Waddell Signs are associated with decreased functional performance and greater subjective pain levels, though they provide no information on the etiology of pain. Waddell Signs cannot be used to predict or diagnose malingering. Their presence of three out of five signs may most appropriately be viewed as a "yellow flag", or screening test, alerting clinicians to those patients who require a more comprehensive approach to their assessment and care plan. Therefore, if three out of five Waddell Signs are positive in a patient with subacute or chronic back pain, a psychosocial evaluation should be part of the total evaluation of the patient. Refer to Personality/Psychological/Psychosocial Evaluation.

d. Relationship To Work. This includes a statement of the probability that the illness or injury is work-related. If further information is necessary to determine work relatedness, the physician should clearly state what additional diagnostic studies or job information is required.

2. Radiographic imaging of the lumbosacral spine is a generally accepted, well-established and widely used diagnostic procedure when specific indications based on history and/or physical examination are present. There is

some evidence that early radiographic imaging without clear indications is associated with prolonged care, but no difference in functional outcomes. Therefore, it should not be routinely performed without indications. The mechanism of injury and specific indications for the radiograph should be listed on the request form to aid the radiologist and x-ray technician. Suggested indications include:

a. history of significant trauma, especially blunt trauma or fall from a height;

b. age over 55 years;

c. unexplained or persistent low back pain for at least 6 weeks or pain that is worse with rest;

d. localized pain, fever, constitutional symptoms, or history or exam suggestive of intravenous drug abuse, prolonged steroid use, or osteomyelitis;

e. suspected lesion in the lumbosacral spine due to systemic illness such as a rheumatic/rheumatoid disorder or endocrinopathy. Suspected lesions may require special views;

f. past medical history suggestive of pre-existing spinal disease, osteoporosis, spinal instrumentation, or cancer; and

g. prior to high-velocity/low amplitude manipulation or Grade IV to V mobilization.

3. Laboratory Testing. Laboratory tests are generally accepted, well-established and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, or underlying rheumatologic disorder, connective tissue disorder, or based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. Tests include, but are not limited to:

a. complete blood count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;

b. erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP), can be used to detect evidence of a rheumatologic, infectious, or connective tissue disorder;

c. serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease;

d. urinalysis for bacteria (usually with culture and sensitivity), calcium, phosphorus, hydroxyproline, or hematuria; and

e. liver and kidney function may be performed for prolonged anti-inflammatory use or other medications requiring monitoring.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

## **§2019. Follow-Up Diagnostic Imaging and Testing Procedures**

A. One diagnostic imaging procedure may provide the same or distinctive information as does another procedure. Therefore, the prudent choice of a single diagnostic procedure, a complement of procedures or a sequence of procedures will optimize diagnostic accuracy; maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients.

B. All imaging procedures have a degree of specificity and sensitivity for various diagnoses. No isolated imaging test can assure a correct diagnosis. Clinical information obtained by history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results.

C. Magnetic resonance imaging (MRI), myelography, or Computed Axial Tomography (CT) scanning following myelography may provide useful information for many spinal disorders. When a diagnostic procedure, in conjunction with clinical information, can provide sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging studies are generally accepted, well-established and widely used diagnostic procedures. In the absence of myelopathy, or progressive neurological changes, or history of cancer, imaging usually is not appropriate until conservative therapy has been tried and failed. Six to eight weeks of treatment are usually an adequate period of time before an imaging procedure is in order, but the clinician should use judgment in this regard. When indicated, imaging studies can be utilized for further evaluation of the low back, based upon the mechanism of injury, symptoms, and patient history. Prudent choice of a single diagnostic procedure, a complementary combination of procedures, or a proper sequential order of complementary procedures will help ensure maximum diagnostic accuracy and minimize adverse effect to the patient. When the findings of the diagnostic imaging and testing procedures are not consistent with the clinical examination, the clinical findings should have preference. There is good evidence that in the asymptomatic population, disc bulges, annular tears, or high intensity zone areas, and disc height loss are prevalent 40–60 percent of the time depending on the condition, study, and age of the patient. Therefore, the existence of these anatomic findings should not be considered relevant without physiologic and clinical correlation in an individual patient. The studies below are listed in frequency of use, not importance:

a. Magnetic Resonance Imaging (MRI) is rarely indicated in patients with non-traumatic acute low back pain with no neuropathic signs or symptoms. It is generally the first follow-up imaging study in individuals who respond poorly to proper initial conservative care. MRI is useful in suspected nerve root compression, myelopathy, masses, infections, metastatic disease, disc herniation, annular tear, and cord contusion or severe incapacitating pain. MRI is contraindicated in patients with certain implants.

i. In general, the high field, conventional, MRI provides better resolution. A lower field scan may be indicated when a patient cannot fit into a high field scanner or who is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist.

ii. Specialized MRI Scans

(a). MRI with three-dimensional reconstruction. On rare occasions, MRI with three-dimensional reconstruction views may be used as a pre-surgical diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures.

(b). Dynamic-kinetic MRI of the spine. Dynamic-kinetic MRI of the spine uses an MRI unit configured with a top-front open design which enables upright, weight-bearing patient positioning in a variety of postures not obtainable with the recumbent images derived from conventional, closed unit MRI systems. Imaging can be obtained in flexion, extension, and rotation of the spine, as well as in erect positioning. There is a theoretical advantage to imaging sequences obtained under more physiologic conditions than in the supine position. There is currently ongoing research to establish whether the theoretical advantages of positional and kinetic MRI result in improved sensitivity and specificity in detecting spine pathology. Currently it remains investigational and is not recommended until the correlation with clinical syndromes and outcomes is firmly established.

b. Computed Axial Tomography (CT) provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic evaluation. It may sometimes be done as a complement to MRI scanning to better delineate bony osteophyte formation in the neural foramen. Instrument-scatter reduction software provides better resolution when metallic artifact is of concern.

c. Myelography is the injection of radiopaque material into the spinal subarachnoid space, with x-rays then taken to define anatomy. It may be used as a diagnostic procedure to obtain accurate information of characteristics, location, and spatial relationships among soft tissue and bony structures. Myelography is an invasive procedure with complications including nausea, vomiting, headache, convulsion, arachnoiditis, cerebral-spinal fluid (CSF) leakage, allergic reactions, bleeding, and infection. Therefore, myelography should only be considered when CT and MRI are unavailable, for morbidly obese patients or those who have undergone multiple operations, and when other tests prove non-diagnostic. The use of small needles and a less toxic, water-soluble, nonionic contrast is recommended.

d. CT Myelogram provides more detailed information about relationships between neural elements and surrounding anatomy and is appropriate in patients with multiple prior operations or tumorous conditions.

e. Single Photon Emission Computerized Tomography (SPECT). A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans & CT Scans in looking for facet joint pathology.

f. Bone Scan (Radioisotope Bone Scanning) is generally accepted, well-established, and widely used. Bone scanning is more sensitive but less specific than MRI. <sup>99m</sup>Technetium diphosphonate uptake reflects osteoblastic activity and may be useful in diagnosing metastatic/primary bone tumors, stress fractures, osteomyelitis, and

inflammatory lesions, but cannot distinguish between these entities.

g. Other Radioisotope Scanning: Indium and gallium scans are generally accepted, well-established, and widely used procedures usually to help diagnose lesions seen on other diagnostic imaging studies. <sup>67</sup>Gallium citrate scans are used to localize tumor, infection, and abscesses. <sup>111</sup>Indium-labeled leukocyte scanning is utilized for localizing infection or inflammation.

h. Dynamic [Digital] Fluoroscopy: Dynamic [Digital] Fluoroscopy of the lumbar spine measures the motion of intervertebral segments using a videofluoroscopy unit to capture images as the subject performs lumbar flexion and extension, storing the anatomic motion of the spine in a computer. Currently it is not recommended for use in the diagnosis of lumbar instability, since there is limited information on normal segmental motion for the age groups commonly presenting with low back pain, and diagnostic criteria for specific spinal conditions are not yet defined. No studies have yet demonstrated predictive value in terms of standard operative and non-operative therapeutic outcomes.

2. Other tests. The following diagnostic procedures in this subsection are listed in alphabetical order, not by importance:

a. Electrodiagnostic Testing

i. Electromyography (EMG), Nerve Conduction Studies (NCS) These are generally accepted, well-established and widely used diagnostic procedures. EMG and NCS, when performed and interpreted by a trained physician/electrophysiologist, may be useful for patients with suspected neural involvement whose symptoms are persistent or unresponsive to initial conservative treatments. They are used to differentiate peripheral neural deficits from radicular and spinal cord neural deficits and to rule out concomitant myopathy. However, F-Wave Latencies are not diagnostic for radiculopathy.

(a). In general, EMG and NCS are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electrodiagnostic studies may provide useful, correlative neurophysiological information that would be otherwise unobtainable from the radiologic studies discussed above.

ii. Portable Automated Electrodiagnostic Device (also known as Surface EMG) is not a substitute for conventional diagnostic testing in clinical decision-making, and therefore, is not recommended.

iii. Somatosensory Evoked Potential (SSEP) is not recommended to identify radiculopathy. It may be used to evaluate myelopathy and other rare neurological disorders such as neurogenic bladder and sexual dysfunction.

iv. Current Perception Threshold (CPT) Evaluation may be useful as a screening tool, but its diagnostic efficacy in the evaluation of industrial low back pain has not been determined. Therefore, CPT is not recommended as a diagnostic tool.

v. Large Array Surface Electromyography measures low back muscle activity using a fixed array of 63 electrodes arranged in nine rows and seven columns between the seventh thoracic spinous process and the iliac crest. The array simultaneously collects myoelectric data from multifidus, iliocostalis, quadratus lumborum, and other

lumbar muscles, which is analyzed for patterns of activity in these muscle groups. It is used in researching physiologic changes and adaptations to back pain, but is not recommended as a diagnostic procedure for individuals with back pain due to a lack of interpretive standards.

vi. Surface EMG in combination with Range of Motion and/or Functional Capacity Evaluation. This is designed to detect differences between persons with and without low back pain, measuring signals in lumbar flexion which show that painful paraspinal muscles fail to relax fully. It may show aspects of the pathophysiology of muscle activity which advance the scientific understanding of low back pain. The test also purports to determine the significance of disc pathology and the age of an injury. It has not been evaluated in a setting which tests a spectrum of patients commonly seen in clinical practice, using an interpretation which is tested against a diagnostic reference standard. Therefore, it is not suitable as a diagnostic test for low back pain and its use for this purpose is not recommended.

b. Injections—Diagnostic

i. Description. Diagnostic spinal injections are generally accepted, well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy.

ii. Indications. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms. Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be primary pain generators. Patients should not receive all of the diagnostic blocks listed merely in an attempt to identify 100 percent of the pain generators.

iii. The interpretation of the test results are primarily based on functional change, symptom report, and pain response (via a recognized pain scale), before and at an appropriate time period after the injection. The diagnostic significance of the test result should be evaluated in conjunction with clinical information and the results of other diagnostic procedures. Injections with local anesthetics of differing duration may be used to support a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose low back pain. (Refer to Injections—Therapeutic for information on specific injections.)

(a). It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure be evident to other reviewers. This entails, at a minimum, documentation of patient response immediately following the procedure with details of any symptoms with a response and the degree of response. Additionally, a log must be recorded as part of the medical record which documents response, if any, on an hourly basis for, at a minimum, the expected duration of the local anesthetic phase of the procedure. Responses must be

identified as to specific body part (e.g., low back, leg pain). The practitioner must identify the local anesthetic used and the expected duration of response for diagnostic purposes.

(b). Multiple injections provided at the same session without staging may seriously dilute the diagnostic value of these procedures. Practitioners must carefully weigh the diagnostic value of the procedure against the possible therapeutic value.

iv. Special Requirements for Diagnostic Injections. Since multi-planar fluoroscopy during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, neurology or psychiatry. The practitioner should document hands-on training through workshops and/or completed fellowship training with interventional training. They must also be knowledgeable in radiation safety.

v. Complications. General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, urinary retention, and vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation, and CSF leakage, and spinal meningeal abscess. Permanent paresis, anaphylaxis, and arachnoiditis have been rarely reported with the use of epidural steroids.

vi. Contraindications. Absolute contraindications to diagnostic injections include: bacterial infection – systemic or localized to region of injection; bleeding diatheses; hematological conditions; and possible pregnancy.

(a). Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

vii. Specific Diagnostic Injections. In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to “Injections – Therapeutic” for information on specific therapeutic injections.

(a). Medial Branch Blocks are generally accepted diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy). ISIS suggests controlled blocks, using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block, the patient should report a reduction of pain of 50 percent or greater relief from baseline for the length of time appropriate for the local anesthetic used. In almost all cases, this will mean a reduction of pain to one or two on the Visual Analog Scale (VAS) 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range of motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting.

Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations or American Society of Interventional Pain Physicians (ASIPP)

(i). A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics of varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

[a]. Frequency and Maximum Duration: May be repeated once for comparative blocks. Limited to four levels

[b]. Transforaminal injections/Spinal Selective Nerve Block (SSNB) are generally accepted and useful in identifying spinal pathology. When performed for diagnosis, small amounts of local anesthetic up to a total volume of 1.0 cc should be used to determine the level of nerve root irritation. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in nerve-root generated pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS).

[i]. Time to produce effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients.

[ii]. Frequency and Maximum Duration: Once per suspected level. Limited to two levels

c. Zygapophyseal (Facet) Blocks

i. Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks.

ii. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and a 50 percent reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to Therapeutic Spinal Injections).

(a). Time to produce effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients;

(b). Frequency and maximum Duration: Once per suspected level, limited to two levels.

d. Sacroiliac Joint Injection

i. Description. A generally accepted Injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under fluoroscopic guidance. Long-term therapeutic effect has not yet been established.

ii. Indications. Primarily diagnostic to rule out sacroiliac joint dysfunction versus other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick’s test) and at least 50 percent pain relief on post-injection physical exam

(as measured by accepted pain scales such as a VAS) correlated with functional improvement. Sacroiliac joint blocks should facilitate functionally directed rehabilitation programs.

(a). Time to produce effect: Up to 30 minutes for local anesthetic;

(b). Frequency and Maximum Duration: 1;

e. Personality /Psychological /Psychiatric /Psychosocial Evaluation

i. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

ii. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

(a). employment history;

(b). interpersonal relationships-both social and work;

(c). patient activities;

(d). current perception of the medical system;

(e). current perception/attitudes toward employer/job;

(f). results of current treatment;

(g). risk factors and psychological comorbidities that may influence;

(h). outcome and that may require treatment:

(i). childhood history, including history of childhood psychological trauma, abuse and family history of disability;

(ii). personality/ psychological/ psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors

that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

[a]. Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

f. Provocation Discography

i. Description. Discography is an accepted, but rarely indicated, invasive diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, pre-conditions, special considerations, procedures, reporting requirements, and results are carefully and specifically followed. Results should be interpreted judiciously.

ii. Indications. Discography may be indicated when a patient has a history of functionally limiting, unremitting low back pain of greater than four months duration, with or without leg pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.

(a). Discography may prove useful for the evaluation of the pre-surgical spine, such as pseudarthrosis, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.

(b). Discography may show disc degeneration and annular disruption in the absence of low back pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential back pain. Because patients with mild back pain should not be considered for invasive treatment, discography should not be performed on these patients. In symptomatic patients with annular tears on discography, the side of the tear does not necessarily correlate with the side on which the symptoms occur. The presence of an annular tear does not necessarily identify the tear as the pain generator.

(c). Discography is not useful in previously operated discs, but may have a limited place in the work-up of pseudarthrosis. Discography may prove useful in evaluating the number of lumbar spine levels that might require fusion. CT-Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.

iii. Pre-conditions for provocation discography include all of the following.

(a). A patient with functionally limiting, unremitting back and/or leg pain of greater than four months duration in whom conservative treatment has been unsuccessful and in whom the specific diagnosis of the pain generator has not been made apparent on the basis of other noninvasive imaging studies (e.g., MRI, CT, plain films, etc.). It is recommended that discography be reserved for use

in patients with equivocal MRI findings, especially at levels adjacent to clearly pathological levels. Discography may be more sensitive than MRI or CT in detecting radial annular tears. However, radial tears must always be correlated with clinical presentation.

(b). Psychosocial Evaluation has been completed. There is some evidence that false positives and complaints of long-term pain arising from the procedure itself occur more frequently in patients with somatoform disorders. Therefore, discograms should not be performed on patients with somatoform disorders.

(c). Patients who are considered surgical candidates (e.g., symptoms are of sufficient magnitude and the patient has been informed of the possible surgical options that may be available based upon the results of discography). Discography should never be the sole indication for surgery.

(d). Informed consent regarding the risks and potential diagnostic benefits of discography has been obtained.

iv. Complications—include, but are not limited to, discitis, nerve damage, chemical meningitis, pain exacerbation, and anaphylaxis therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

v. Contraindications—include:

(a) active infection of any type or continuing antibiotic treatment for infection; and/or

(b) bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or

(c) significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or

(d) presence of clinical myelopathy; and/or

(e) effacement of the cord, thecal sac or circumferential absence of epidural fat; and

(f) known allergic reactions.

vi. Special Considerations

(a). Discography should not be performed by the physician expected to perform the therapeutic procedure. The procedure should be carried out by an experienced individual who has received specialized training in the technique of provocation discography.

(b). Discography should be performed in a blinded format that avoids leading the patient with anticipated responses. The procedure should always include one or more disc levels thought to be normal or non-painful in order to serve as an internal control. The patient should not know what level is being injected in order to avoid spurious results. Abnormal disc levels may be repeated to confirm concordance.

(c). Sterile technique must be utilized.

(d). Judicious use of light sedation during the procedure is acceptable, represents the most common practice nationally at the current time, and is recommended by most experts in the field. The patient must be awake and able to accurately report pain levels during the provocation portion of the procedure.

(e). The discography should be performed using a manometer to record pressure. Pressure should not exceed 50 pounds per square inch (psi) above opening pressure.

(f). Intradiscal injection of local anesthetic may be carried out after the provocation portion of the examination and the patient's response.

(g). It is recommended that a post-discogram CT be considered as it frequently provides additional useful information about disc morphology or other pathology.

vii. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of (a) disc morphology (b) the pain response, and (c) the pressure at which pain is produced. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

(a). When discography is performed to identify the source of a patient's low-back pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

(b). Caution should be used when interpreting results from discography. Several studies indicate that a false positive discogram for pain is likely above a pressure reading of 50 psi above opening pressure. The false positive rate appears to drop to approximately 25 percent using a pressure of 20 psi above opening pressure in a population with low back pain.

(i). Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

[a]. Grade 0 = Normal Nucleus

[b]. Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.

[c]. Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.

[d]. Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.

[e]. Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.

[f]. Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.

(ii). Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society (ISIS) Guidelines or American Society of Interventional Pain Physicians (ASIPP) Guidelines. The report must include the level of concordance for back pain and /or leg pain using a 10-point VAS, or similar quantitative assessment. It should be noted that change in the VAS scale before and after provocation is more important than the number reported.

[a]. Unequivocal Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. the pain should be registered at least 7 on a 10-point VAS.

[iii]. the pain is reproduced at a pressure of less than 15 psi above opening pressure; and

[iv]. stimulation of two adjacent discs does not produce pain at all

[b]. Definite Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. the pain should be registered as at least 7 on a 10-point VAS.

[iii]. the pain is reproduced at a pressure of less than 15 psi above opening pressure; and

[iv]. stimulation of at least one adjacent disc does not produce pain at all

[c]. Highly Probable Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain

[ii]. that pain should be registered as at least 7 on a 10-point VAS.

[iii]. that the pain is reproduced at a pressure of less than 50 psi above opening pressure; and

[iv]. stimulation of two adjacent discs does not produce pain at all

[d]. Probable Discogenic Pain

[i]. stimulation of the target disc reproduces concordant pain;

[ii]. that pain should be registered as at least 7 on a 10-point VAS;

[iii]. the pain is reproduced at a pressure of less than 50 psi above opening pressure; and

[iv]. stimulation of one adjacent disc does not produce pain at all, and stimulation of another adjacent disc at greater than 50 psi, produces pain, but the pain is not concordant.

[e]. Multiple combinations of factors are possible. However, if the patient does not qualify for at least a 'Probable Discogenic Pain' level, then the discogram should be considered negative. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.

[i]. Time Parameters for Provocation Discography are as follows:

aa. Frequency: One time only

bb. Maximum: Repeat Discography is rarely indicated

g. Thermography is an accepted and established procedure, but has no use as a diagnostic test for low back pain. It may be used to diagnose regional pain disorders and in these cases, refer to the OWCA's Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

3. Special tests are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and physical work demand classifications and tolerance. The procedures in this subsection are listed in alphabetical order, not by importance.

a. Computer-Enhanced Evaluations: may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range of motion, endurance, or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment and demonstrated motivation. These evaluations should not be used alone to determine return to work restrictions.

i. Frequency—one time for evaluation. Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. Functional Capacity Evaluation (FCE) is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range of motion, coordination and strength, worker habits, employability as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; and non-material and material handling activities.

i. When an FCE is being used to determine return to a specific jobsite, the provider is responsible for fully understanding the job duties. A jobsite evaluation is frequently necessary. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

ii. Full FCEs are sometimes not necessary. If Partial FCEs are performed, it is recognized that all parts of the FCE that are not performed are considered normal. In many cases, a work tolerance screening will identify the ability to perform the necessary job tasks.

(a). Frequency can be used initially to determine baseline status. Additional evaluations can be performed to monitor and assess progress and aid in determining the endpoint for treatment.

c. Job site Evaluation: is a comprehensive analysis of the physical, mental, and sensory components of a specific job. These components may include, but are not limited to: postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; sensation; coordination; environmental requirements repetitiveness; and essential job functions. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

i. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work.

ii. Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following:

(a). to determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

(b). to make recommendations for, and to assess the potential for ergonomic changes;

(c). to provide a detailed description of the physical and cognitive job requirements;

(d). to assist the patient in their return to work by educating them on how they may be able to do their job more safely in a bio-mechanically appropriate manner;

(e). to give detailed work/activity restrictions.

(i). Frequency—one time with additional visits as needed for follow-up per jobsite.

d. Vocational Assessment. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

i. Frequency—one time with additional visits as needed for follow-up

e. Work Tolerance Screening is a determination of an individual's tolerance for performing a specific job as based on a job activity or task and may be used when a full Functional Capacity Evaluation is not indicated. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential.

i. Frequency—one time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

#### **§2021. Therapeutic Procedures—Non-Operative**

A. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to "Return-to-Work" in this section for detailed information.

C. Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

D. Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

E. Lastly, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. Home therapy is an important component of therapy and may include active and passive therapeutic procedures, as well as, other modalities to assist in alleviating pain, swelling, and abnormal muscle tone.

G. Non-operative treatment procedures for low back pain can be divided into two groups: conservative care and rehabilitation. Conservative care is treatment applied to a problem in which spontaneous improvement is expected in 90 percent of the cases within three months. It is usually provided during the tissue-healing phase and lasts no more than six months, and often considerably less. Rehabilitation is treatment applied to a more chronic and complex problem in a patient with de-conditioning and disability. It is provided during the period after tissue healing to obtain maximal medical recovery. Treatment modalities may be utilized sequentially or concomitantly depending on chronicity and complexity of the problem, and treatment plans should always be based on a diagnosis utilizing appropriate diagnostic procedures.

H. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation, and there is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Acupuncture: is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

b. Acupuncture with Electrical Stimulation: is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

c. Total Time Frames For Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

i. time to produce effect: three to six treatments;

- ii. frequency: one to three times per week;
- iii. optimum duration: one to two months;
- iv. maximum duration: 14 treatments.

(a). Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

(b). Other Acupuncture Modalities. Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities and time frames.

2. Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

a. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is to normalize physiology to the pre-injury status to the extent possible, and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

b. Indications for biofeedback include individuals who are suffering from musculoskeletal injury in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often used in conjunction with other treatment modalities.

- i. time to produce effect: three to four sessions;
- ii. frequency: one to two times per week;
- iii. optimum duration: five to six sessions;
- iv. maximum duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive functional gains.

### 3. Injections—Therapeutic

#### a. Therapeutic Spinal Injections.

Description—Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology. Injections are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to section E. 11, Active Therapy). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active ROM, strength, and stability. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

i. Special Considerations. For all injections (excluding trigger point), multi-planar fluoroscopic guidance during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle replacement. The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, neurology, surgery, or physiatry. The practitioner should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training in pain medicine with interventional training. They must also be knowledgeable in radiation safety.

ii. Complications. General complications of spinal injections may include transient neurapraxia, local pain, nerve injury, infection, headache, urinary retention, and vasovagal effects. Epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage; and/or spinal meningeal abscess may also occur. Permanent paresis, anaphylaxis, and arachnoiditis have been rarely reported with the use of epidural steroids. With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary-adrenal axis lasting between one and three months.

iii. Contraindications. Absolute contraindications to therapeutic injections include: bacterial infection—systemic or localized to region of injection; bleeding diatheses; hematological conditions, and possible pregnancy.

(a). Relative contraindications to diagnostic injections may include: allergy to contrast, poorly controlled Diabetes Mellitus, and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed

individually by a knowledgeable specialist. It is recommended to refer to Am Society of Regional Anesthesia for anticoagulation guidelines.

iv. Epidural Steroid Injection (ESI)

(a). Description. Epidural steroid injections are injections of corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation in the acute or sub-acute phases of injury, restoring range of motion and, thereby, facilitating progress in more active treatment programs. ESI uses three approaches: transforaminal/Spinal Selective Nerve Block (SNRB), interlaminar (midline), and caudal. The transforaminal/Spinal Selective Nerve Root Block approach is the preferred method for unilateral, single-level pathology and for post-surgical patients. There is good evidence that the transforaminal/Spinal Selective Nerve Root Block approach can deliver medication to the target tissue with few complications and can be used to identify the specific site of pathology. The interlaminar approach is the preferred approach for multi-level pathology or spinal stenosis. Caudal therapeutic injections may be used, but it is difficult to target the exact treatment area, due to diffuse distribution.

(b). Needle Placement. Multi-planar fluoroscopic imaging is required for all epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle replacement.

(c). Indications. There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). Up to 80 percent of patients with radicular pain may have initial relief. However, only 25-57 percent are likely to have excellent long-term relief. Although there is no evidence regarding the effectiveness of ESI for non-radicular disc herniation, it is an accepted intervention. Only patients who have pain affected by activity and annular tears verified by appropriate imaging may have injections for axial pain.

(i). There is some evidence that ESI injections are not effective for spinal stenosis without radicular findings. Additionally, there is some evidence that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful outcome from ESIs.

[a]. Time to produce effect: Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

[b]. Frequency: Interlaminar (midline) or caudal techniques should be limited to one level per session. Transforaminal epidural injections should be limited to two levels per session. Whether injections are repeated depends upon the patient's response to the previous injection. Subsequent injections may occur after one to two weeks if patient response has been favorable. Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. Injections should provide a positive patient response: Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance,

activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

[c]. Optimum duration: Usually one to three injection(s) over a period of six months depending upon each patient's response and functional gain.

[d]. Maximum duration: Two sessions (consisting of up to three injections each) may be done in one year, as per the patient's response to pain and function. Patients should be reassessed after each injection for an 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

v. Zygapophyseal (Facet) Injection

(a). Description—a generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. Medial branch nerve blocks are diagnostic only. There is conflicting evidence to support a long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

(b). Indications—patients with pain 1) suspected to be facet in origin based on exam findings and 2) affecting activity; OR patients who have refused a rhizotomy; OR patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

(i). Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS).

[a]. Time to produce effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

[b]. Frequency: one injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

[c]. Optimum duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

[d]. Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

vi. Sacroiliac Joint Injection

(a). Description—a generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under radiographic guidance. May include the use of corticosteroids. Long-term therapeutic effect has not yet been established.

(b). Indications—primarily diagnostic to rule out sacroiliac joint dysfunction vs. other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick’s test) on post-injection physical exam. These injections may be repeated if they result in increased documented functional benefit for at least 6 weeks and at least a 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS). Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

(i). Time to produce effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

(ii). Frequency and optimum duration: two to three injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection.

(iii). Maximum duration: four injections per year.

(iv). Intradiscal Steroid Therapy

[a]. Intradiscal Steroid Therapy consists of injection of a steroid preparation into the intervertebral disc under fluoroscopic guidance at the time of discography. There is good evidence that it is not effective in the treatment of suspected discogenic back pain and its use is not recommended.

[b]. Radio Frequency Medial Branch Neurotomy/Facet Rhizotomy:

[i]. Description—a procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used.

aa. There is good evidence to support Radio Frequency Medial Branch Neurotomy in the cervical spine but benefits beyond one year are not yet established. Evidence in the lumbar spine is conflicting; however, the procedure is generally accepted. In one study, 60 percent of patients maintained at least 90 percent pain relief at 12 months. Radio-frequency Medial Branch Neurotomy is the procedure of choice over alcohol, phenol, or cryoablation. Precise positioning of the probe using fluoroscopic guidance is required since the maximum effective diameter of the device is a 5x8 millimeter oval. Permanent images should be recorded to verify placement of the device.

[ii]. Indications—those patients with proven, significant, facetogenic pain. A minority of low back patients would be expected to qualify for this procedure. This procedure is not recommended for patients with multiple pain generators or involvement of more than 3 levels of medial branch nerves.

b. Individuals should have met all of the following indications: Pain of well-documented facet origin, unresponsive to active and/or passive therapy, unresponsive to manual therapy, and in which a psychosocial screening has been performed (e.g., pain diagram, Waddell’s signs, thorough psychosocial history, screening questionnaire). It is

generally recommended that this procedure not be performed until three months of active therapy and manual therapy have been completed. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients will have had prior to the procedure, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy.)

c. All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block. ISIS suggests controlled blocks using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block the patient should report a reduction of pain of 50 percent or greater from baseline for the length of time appropriate for the local anesthetic used. In almost all cases this will mean a reduction of pain to one or two on the VAS 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range of motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations.

i. A separate comparative block on a different date may be performed to confirm the level of involvement. A comparative block uses anesthetics with varying lengths of activity.

ii. Complications—Bleeding, infection, or neural injury. The clinician must be aware of the risk of developing a localized neuritis, or rarely, a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures.

iii. Post-Procedure Therapy—active therapy. Implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-procedure week, barring complications. Instruction and participation in a long-term home-based program of ROM, core strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished over a period of four to ten visits post-procedure.

iv. Requirements for Repeat Radiofrequency Medial Branch Neurotomy (or additional-level RF Neurotomies): In some cases pain may recur. Successful RF Neurotomy usually provides from six to eighteen months of relief.

(a). Before a repeat RF Neurotomy is done, a confirmatory medial branch injection should be performed if the patient’s pain pattern presents differently than the initial evaluation. In occasional patients, additional levels of RF neurotomy may be necessary. The same indications and limitations apply.

d. Sacro-iliac (SI) Joint Radiofrequency Denervation is a denervation of the SI joint. This procedure has limited evidence to support efficacy for its use and may be considered for therapeutic purposes.

e. Trigger Point Injections and Dry Needling Treatment

i. Description. Trigger point injections are a generally accepted treatment. Trigger point treatment can consist of dry needling or injection of local anesthetic, with

or without corticosteroid, into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

(a). There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

(b). Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

(i). Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six-week time frame. However, trigger point injections may be occasionally effective when utilized in the patient with immediate, acute onset of low back pain.

(c). Complications. Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, penetration of viscera, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

(i). time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia;

(ii). frequency: Weekly. Suggest no more than 4 injection sites per session per week to avoid significant post-injection soreness;

(iii). optimum duration: four Weeks;

(iv). maximum duration: eight weeks.

Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

(v). Prolotherapy also known as sclerotherapy consists of a series of injections of hypertonic

dextrose, with or without glycerine and phenol, into the ligamentous structures of the low back. Its proponents claim that the inflammatory response to the injections will recruit cytokine growth factors involved in the proliferation of connective tissue, stabilizing the ligaments of the low back when these structures have been damaged by mechanical insults.

[a]. There are conflicting studies concerning the effectiveness of Prolotherapy in the low back. Lasting functional improvement has not been shown. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, the use of Prolotherapy for low back pain is not recommended.

f. Epiduroscopy and Epidural Lysis of Adhesions: is an investigational treatment of low back pain. It involves the introduction of a fiberoptic endoscope into the epidural space via the sacral hiatus. With cephalad advancement of the endoscope under direct visualization, the epidural space is irrigated with saline. Adhesiolysis may be done mechanically with a fiberoptic endoscope. The saline irrigation is performed with or without epiduroscopy and is intended to distend the epidural space in order to obtain an adequate visual field. It is designed to produce lysis of adhesions, which are conjectured to produce symptoms due to traction on painful nerve roots. Saline irrigation is associated with risks of elevated pressures which may impede blood flow and venous return, possibly causing ischemia of the cauda equina and retinal hemorrhage.

i. Other complications associated with instrumented lysis include catheter shearing, need for catheter surgical removal, infection (including meningitis), hematoma, and possible severe hemodynamic instability during application. Although epidural adhesions have been postulated to cause chronic low back pain, studies have failed to find a significant correlation between the level of fibrosis and pain or difficulty functioning. Studies of epidural lysis demonstrate no transient pain relief from the procedure. Given the low likelihood of a positive response, the additional costs and time requirement, and the possible complications from the procedure, epidural injection, or mechanical lysis, is not recommended.

(a). Epiduroscopy-directed steroid injections are also not recommended as there is no evidence to support an advantage for using an epiduroscope with steroid injections.

4. Medications use in the treatment of low back injuries is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter medications as well as the contents of over-the-counter herbal products. The following are listed in alphabetical order:

a. Acetaminophen: is an effective analgesic with antipyretic but not anti-inflammatory activity. Acetaminophen is generally well tolerated, causes little or no gastrointestinal irritation, and is not associated with ulcer

formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations may contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed 2250 mg per 24-hour period, from all sources, including narcotic-acetaminophen combination preparations.

i. Optimum duration: 7 to 10 days.

ii. Maximum duration: Chronic use as indicated on a case-by-case basis. Use of this substance long-term for 3 days per week or greater may be associated with rebound pain upon cessation.

b. Muscle Relaxants: are appropriate for muscle spasm with pain. There is strong evidence that muscle relaxants are more effective than placebo for providing short-term pain relief in acute low back pain. When prescribing these agents, physicians must seriously consider side effects of drowsiness or dizziness and the fact that benzodiazepines may be habit-forming.

i. optimum duration: one week;

ii. maximum duration: two weeks (or longer if used only at night).

c. Narcotics: should be primarily reserved for the treatment of severe low back pain. In mild to moderate cases of low back pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

i. Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the narcotic prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.

(a). optimum duration: three to seven days.

(b). maximum duration: two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management.

(c). Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advise that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, Histamine 2 Blockers or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver

function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete Blood Count (CBC), and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

(i). Non-Selective Nonsteroidal Anti-Inflammatory Drugs

[a]. Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

[i]. optimal duration: one week;

[ii]. maximum duration: one year. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

[ii]. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors

[b]. COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency, thus renal function may need monitoring.

[c]. COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

[i]. optimal duration: 7 to 10 days

[ii]. maximum duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

d. Oral Steroids: have limited use but are accepted in cases requiring potent anti-inflammatory drug effect. There is no evidence supporting oral steroids for patients with low back pain with or without radiculopathy and are not recommended.

e. Intravenous Steroids: The risks of permanent neurological damage from acute spinal cord compression generally outweigh the risks of pharmacologic side effects of steroids in an emergent situation.

f. Psychotropic/Anti-anxiety/Hypnotic Agents: may be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Antidepressant medications, such as tricyclics and, Selective Serotonin reuptake inhibitors (SSRIs) and norepinephrine reuptake inhibitors (SSNRIs) are useful for affective disorder and

chronic pain management. Tricyclic antidepressant agents, in low dose, are useful for chronic pain but have more frequent side effects. Anti-anxiety medications should generally be limited to short-term use. Combinations of the above agents may be useful. As a general rule, providers (i.e., physician or medical psychologist) should access the patient's prior history of substance abuse or depression prior to prescribing any of these agents. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not routinely recommended. Refer to the Chronic Pain Guidelines which give a detailed discussion regarding medication use in chronic pain management.

- i. optimum duration: one to six months;
- ii. maximum duration: 6 to 12 months, with monitoring.

- g. Tramadol is useful in relief of low back pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Although Tramadol may cause impaired alertness, it is generally well tolerated, does not cause gastrointestinal ulceration, or exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, SSRIs, and tricyclic antidepressants. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation and is not recommended for those with prior opioid addiction.

- i. optimum duration: three to seven days;
- ii. maximum duration: two weeks. Use beyond two weeks is acceptable in appropriate cases.

#### 5. Occupational rehabilitation programs

- a. Non-Interdisciplinary. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to active treatment and/or simulated/real work.

- i. Work Conditioning

- (a). These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. Work conditioning should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

- (i). length of visit: one to two hours per day;

- (ii). frequency: two to five visits per week;

- (iii). optimum duration: two to four weeks

- (iv). maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

- ii. Work Simulation

- (a). Work simulation is a program where an individual completes specific work-related tasks for a

particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

- (i). length of visit: two to six hours per day;

- (ii). frequency: two to five visits per week;

- (iii). optimum duration: two to four weeks;

- (iv). Maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

- (b). Interdisciplinary: programs are well-established treatment for patients with sub-acute and functionally impairing low back pain. They are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured worker's program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. Programs should include cognitive-behavioral therapy as there is good evidence for its effectiveness in patients with chronic low back pain. These programs are for patients with greater levels of disability, dysfunction, de-conditioning and psychological involvement. For patients with chronic pain, refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

- (i). Work Hardening

- [a]. Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

- [b]. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; occupational therapist; physical therapist; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, vocational specialist or Certified Biofeedback Therapist.

- [i]. length of visit: Up to 8 hours/day;

- [ii]. frequency: two to five visits per week;

- [iii]. optimum duration: two to four weeks;

- [iv]. maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

- (ii). Spinal Cord Programs

[a]. Spinal Cord Systems of Care provide coordinated, case-managed, and integrated service for people with spinal cord dysfunction, whether due to trauma or disease. The system includes an inpatient component in an organization licensed as a hospital and an outpatient component. Each component endorses the active participation and choice of the persons served throughout the entire program. The Spinal Cord System of Care also provides or formally links with key components of care that address the lifelong needs of the persons served.

[b]. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified and trained in rehabilitation, a case manager, occupational therapy, physical therapy, psychologist, rehabilitation RN and MD, and therapeutic recreation specialist. As appropriate, the team may also include: rehabilitation counselor, respiratory therapist, social worker, or speech-language pathologist.

[c]. Timeframe durations for any spinal cord program should be determined based upon the extent of the patient's injury and at the discretion of the rehabilitation physician in charge.

#### 6. Orthotics

a. Foot Orthoses and Inserts are accepted interventions for spinal disorders that are due to aggravated mechanical abnormalities, such as leg length discrepancy, scoliosis, or lower extremity misalignment. Shoe insoles or inserts may be effective for patients with acute low back problems who stand for prolonged periods of time.

b. Lumbar Support Devices include backrests for chairs and car seats. Lumbar supports may provide symptomatic relief of pain and movement reduction in cases of chronic low back problems.

c. Lumbar Corsets and Back Belts. There is insufficient evidence to support their use. They are an accepted treatment with limited application. The injured worker should be advised of the potential harm from using a lumbar support for a period of time greater than that which is prescribed. Harmful effects include de-conditioning of the trunk musculature, skin irritation, and general discomfort.

d. Lumbosacral Bracing. Rigid bracing devices are well accepted and commonly used for post-fusion, scoliosis, and vertebral fractures.

7. Patient Education. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed:

a. time to produce effect: Varies with individual patient;

b. frequency: Should occur at every visit.

8. Personality/psychological/psychiatric/psychosocial intervention Psychosocial treatment is generally accepted, widely used, and well-established Intervention. This group

of therapeutic and diagnostic modalities includes, but is not limited to, individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis, and meditation. Any evaluation or diagnostic workup should clarify and distinguish between pre-existing versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. There is some evidence that early cognitive-behavioral treatment reduces health care use in comparison to written information alone. This can be used alone, or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines:

a. time to produce effect: two to four weeks;

b. frequency: one to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly;

c. optimum duration: six weeks to three months;

d. maximum duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required and if further counseling beyond three months is indicated, extensive documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every four to six weeks during treatment.

9. Restriction of Activities. Continuation of normal daily activities is the recommendation for acute and chronic low back pain without neurologic symptoms. There is good evidence against the use of bed rest in cases without neurologic symptoms. Bed rest may lead to de-conditioning and impair rehabilitation. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with low back pain.

10. Return-to-Work. Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months. It is imperative that the patient be educated regarding the benefits of return-to-work, work restrictions, and follow-up if problems arise. When attempting to return a patient to work after a specific injury, clear objective restrictions of activity level should be made. An accurate job description with detailed physical duty restrictions is often necessary to assist the physician in making return-to-work recommendations. This may require a jobsite evaluation.

a. Employers should be prepared to offer transitional work. This may consist of temporary work in a less demanding position, return to the regular job with restrictions, or gradual return to the regular job. Company policies which encourage return-to-work with positive communication are most likely to have decreased worker disability.

b. Return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Due to the large spectrum of injuries

of varying severity and varying physical demands in the work place, it is not possible to make specific return-to-work guidelines for each injury. Therefore, the OWCA recommends the following:

c. Establishment of a Return-To-Work Status: Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan, and addressed at every visit. A description of daily activity limitations is part of any treatment plan and should be the basis for restriction of work activities. In most non-surgical cases, the patient should be able to return-to-work in some capacity or in an alternate position consistent with medical treatment within several days unless there are extenuating circumstances. Injuries requiring more than two weeks off work should be thoroughly documented.

d. Establishment of Activity Level Restrictions. Communication is essential between the patient, employer, and provider to determine appropriate restrictions and return-to-work dates. It is the responsibility of the physician to provide clear concise restrictions, and it is the employer's responsibility to determine if temporary duties can be provided within the restrictions. For low back pain injuries, the following should be addressed when describing the patient's activity level:

i. Lifting limits with the maximum amount of weight to be lifted. This may vary depending on the frequency of the lifting and/or the object height level. Pushing, pulling, as well as bending and twisting at the waist should be considered as well.

ii. Lower body postures such as squatting, kneeling, crawling, stooping, or climbing should include duration and frequency.

iii. Ambulatory level for distance, frequency, and terrain should be specified.

iv. Duration and frequency of sitting, standing, and walking should be delineated. Balance issues should also be considered in these determinations.

v. Use of adaptive devices or equipment for proper office ergonomics to enhance capacities can be included.

e. Compliance with Activity Restrictions: In some cases, compliance with restriction of activity levels may require a complete jobsite evaluation, a functional capacity evaluation (FCE) or other special testing. Refer to the "Special Tests" section of this guideline.

11. Therapy—active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. They are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are

recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

12. The following active therapies are listed in alphabetical order:

a. Activities of Daily Living (ADL) are well-established interventions which involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

- i. time to produce effect: four to five treatments;
- ii. frequency: three to five times per week;
- iii. optimum duration: four to six weeks;
- iv. maximum duration: six weeks.

b. Aquatic Therapy is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, range of motion, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

- i. cannot tolerate active land-based or full-weight bearing therapeutic procedures;
- ii. require increased support in the presence of proprioceptive deficit;
- iii. are at risk of compression fracture due to decreased bone density;
- iv. have symptoms that are exacerbated in a dry environment;
- v. would have a higher probability of meeting active therapeutic goals than in a dry environment.

(a). The pool should be large enough to allow full extremity range of motion and fully erect posture. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

- (i). time to produce effect: four to five treatments;
- (ii). frequency: three to five times per week;
- (iii). optimum duration: four to six weeks;
- (iv). maximum duration: eight weeks;

(b). A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a self-directed dry environment exercise program.

(c). Functional Activities: are well-established interventions which involve the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

- (i). time to produce effect: four to five treatments;
- (ii). frequency: three to five times per week;
- (iii). optimum duration: four to six weeks;
- (iv). maximum duration: six weeks.

(d). Functional Electrical Stimulation: is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. It may be indicated for muscle atrophy due to radiculopathy.

(i). time to produce effect: two to six treatments;

(ii). frequency: three times per week;

(iii). optimum duration: eight weeks;

(iv). maximum duration: eight weeks. If beneficial, provide with home unit.

(e). Neuromuscular Re-education is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception, kinesthetic sense, coordination; education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(i). time to produce effect: two to six treatments;

(ii). frequency: three times per week;

(iii). optimum duration: four to eight weeks;

(iv). maximum duration: eight weeks.

(f). Spinal Stabilization is a generally well-accepted treatment. The goal of this therapeutic program is to strengthen the spine in its neural and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through postures and activities without creating undue vertebral stress.

(i). time to produce effect: four to eight treatments;

(ii). frequency: three to five times per week;

(iii). optimum duration: four to eight weeks;

(iv). maximum duration: eight weeks.

(g). Therapeutic Exercise is a generally well-accepted treatment. Therapeutic exercise, with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception, and coordination, increased range of motion. Therapeutic exercises are used to promote normal movement patterns, and can also include complementary/alternative exercise movement therapy (with oversight of a physician or appropriate healthcare professional).

(i). There is some evidence to support the effectiveness of yoga therapy in alleviating symptoms and decreasing medication use in uncomplicated low back pain.

[a]. time to produce effect: two to six treatments;

[b]. frequency: three to five times per week;

[c]. optimum duration: four to eight weeks;

[d]. maximum duration: eight weeks.

13. Therapy—passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies such as postural stabilization and exercise programs to help control swelling, pain, and inflammation during the active rehabilitation process. Please refer to Section B. 4. General Guideline Principles, Active Interventions. Passive therapies may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." factors such as exacerbation of symptoms, re-injury, interrupted continuity of care, and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" have been completed, alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

i. The following passive therapies are listed in alphabetical order:

(a). Electrical Stimulation (Unattended): is an accepted treatment. Once applied, unattended electrical stimulation requires minimal on-site supervision by the physical therapist, occupational therapist, or other provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation. A home unit should be purchased if treatment is effective and frequent use is recommended.

(i). time to produce effect: two to four treatments;

(ii). frequency: Varies, depending upon indication, between two to three times/day to one time/week. Home unit should be purchased if treatment is effective and frequent use is recommended;

(iii). optimum duration: four treatments for clinic use;

(iv). maximum duration: eight treatments for clinic use.

(b). Iontophoresis is an accepted treatment which consists of the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, salicylate), ischemia (magnesium, mecholy, iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars, and keloids (sodium chloride, iodine, acetate). There is no proven benefit for this therapy in the low back.

- (i). time to produce effect: one to four treatments;
- (ii). frequency: three times per week with at least 48 hours between treatments;
- (iii). optimum duration: four to six weeks;
- (iv). maximum duration: six weeks.

(c). Manipulation is generally accepted, well-established and widely used therapeutic intervention for low back pain. Manipulative Treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(i). High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment. This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as direct- a forceful engagement of a restrictive/pathologic barrier; indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier; the patient actively assists in the treatment; and the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

(ii). High velocity, low amplitude (HVLA) manipulation is performed by taking a joint to its end range of motion and moving the articulation into the zone of accessory joint movement, well within the limits of anatomical integrity. There is good scientific evidence to suggest that HVLA manipulation can be helpful for patients with acute low back pain problems without radiculopathy when used within the first four to six weeks of symptoms. Although the evidence for sub-acute and chronic low back pain and low back pain with radiculopathy is less convincing, it is a generally accepted and well-established intervention for these conditions. Indications for manipulation include joint pain, decreased joint motion, and joint adhesions. Contraindications to HVLA manipulation include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

- [a]. time to produce effect for all types of manipulative treatment: one to six treatments;
- [b]. frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks. For further treatments, twice per week or less to maintain function;
- [c]. optimum duration: 8 to 12 weeks;

[d]. maximum duration: three months. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Refer to the Chronic Pain Guidelines for care beyond three months.

(d). Manipulation under General Anesthesia (MUA): refers to manual manipulation of the lumbar spine in combination with the use of a general anesthetic or conscious sedation. It is intended to improve the success of manipulation when pain, muscle spasm, guarding, and fibrosis appear to be limiting its application in patients otherwise suitable for their use. There have been no high quality studies to justify its benefits given the risks of general anesthetic and conscious sedation. It is not recommended.

(e). Manipulation under Joint Anesthesia (MUJA): refers to manipulation of the lumbar spine in combination with a fluoroscopically guided injection of anesthetic with or without corticosteroid agents into the facet joint at the level being manipulated. There are no controlled clinical trials to support its use. It is not recommended.

(f). Massage—Manual or Mechanical. Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by, or with, the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation and flexibility prior to exercise.

(i). In sub-acute low back pain populations there is good evidence that massage can increase function when combined with exercise and patient education. Some studies have demonstrated a decrease in provider visits and pain medication use with combined therapy. One study indicated improved results with acupressure massage. It is recommended that all massage be performed by trained, experienced therapists and be accompanied by an active exercise program and patient education. In contrast to the sub-acute population, massage is a generally accepted treatment for the acute low back pain population, although no studies have demonstrated its efficacy for this set of patients.

- [a]. time to produce effect: Immediate;
- [b]. frequency: one to two times per week;
- [c]. optimum duration: six weeks;
- [d]. maximum duration: 2 months.

(g). Mobilization (Joint) is a generally well-accepted treatment. Mobilization is passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. For further discussion on Level V joint mobilization please see section on HVLA manipulation [Refer to section 12. d.]. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated

with tissue impingement. Mobilization should be accompanied by active therapy. For Level V mobilization contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

(i). time to produce effect: six to nine treatments;

- (ii). frequency: Up to three times per week;
- (iii). optimum duration: four to six weeks;
- (iv). maximum duration: six weeks.

(h). Mobilization (Soft Tissue): is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

(i). time to produce effect: four to nine treatments

- (ii). frequency: Up to three times per week
- (iii). optimum duration: four to six weeks
- (iv). maximum duration: six weeks

(i). Short-Wave Diathermy is an accepted treatment which involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced re-absorption of hemorrhage/hematoma or edema.

(i). time to produce effect: two to four treatments;

(ii). frequency: two to three times per week up to three weeks;

- (iii). optimum duration: three to five weeks;
- (iv). maximum duration: five weeks.

(j). Superficial Heat and Cold Therapy (excluding Infrared Therapy) is a generally accepted treatment. Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

- (i). time to produce effect: Immediate;
- (ii). frequency: two to five times per week;
- (iii). optimum duration: three weeks as

primary or intermittently as an adjunct to other therapeutic procedures up to two months;

- (iv). maximum duration: 2 months.

(k). Traction—Manual. Is an accepted treatment and an integral part of manual manipulation or joint mobilization. Indications include decreased joint space,

muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation.

(i). time to produce effect: one to three sessions;

(ii). frequency: two to three times per week;

- (iii). optimum duration: 30 days;
- (iv). maximum duration: one month.

(l). Traction—Mechanical. There is no evidence that mechanical traction is useful for low back pain patients without radicular symptoms. Therefore, it is not recommended in this population. It may be trialed in patients with radicular findings, and if successful, should be shifted to home traction. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Non-oscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension. A home lumbar traction unit can be purchased if therapy proves effective.

(i). Time to produce effect: one to three sessions up to 30 minutes. If response is negative after three treatments, discontinue this modality.

(ii). Frequency: two to three times per week. A home lumbar traction unit can be purchased if therapy proves effective.

- (iii). Optimum duration: four weeks
- (iv). Maximum duration: four weeks

(m). Transcutaneous Electrical Nerve Stimulation (TENS). is a generally accepted treatment. TENS should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable functional improvement must be documented prior to the purchase of a home unit.

- (i). time to produce effect: Immediate;
- (ii). frequency: Variable;

(iii). optimum duration: three sessions;

(iv). maximum duration: three sessions. If beneficial, provide with home unit or purchase if effective.

(n). Ultrasound (Including Phonophoresis) is an accepted treatment. Ultrasound uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation.

(i). Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

[a]. time to produce effect: 6 to 15 treatments;

[b]. frequency: three times per week;

[c]. optimum duration: four to eight weeks;

[d]. maximum duration: eight weeks.

(o). Vertebral Axial Decompression (VAX-D)/DRX, 9000 Motorized traction devices which purport to produce non-surgical disc decompression by creating negative intradiscal pressure in the disc space include devices with the trade names of VAX-D and DRX 9000. There are no good studies to support their use. They are not recommended.

(p). Whirlpool/Hubbard Tank is a generally accepted treatment in which conductive exposure to water at varied temperatures that best elicits the desired effect. It generally includes massage by water propelled by a turbine or Jacuzzi jet system and has the same thermal effects as hot packs, if water temperature exceeds tissue temperature. It has the same thermal effects as cold application, if comparable temperature water is used. Indications include the need for analgesia, relaxing muscle spasm, reducing joint stiffness, and facilitating and preparing for exercise.

(i). time to produce effect: two to four treatments

(ii). frequency: three to five times per week

(iii). optimum duration: three weeks as primary, or intermittently as an adjunct to other therapeutic procedures up to two months;

(iv). maximum duration: two months.

14. Vocational rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification highest functional level, motivation, and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation.

a. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

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### **§2023. Therapeutic Procedures—Operative**

A. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, scleratogenous or sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention.

B. Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to

identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.

C. While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of low back pain disorders, timely decision making for operative intervention is critical to avoid de-conditioning and increased disability (exclusive of "emergent" or urgent pathology such as cauda equina syndrome or associated rapidly progressive neurologic loss).

1. In general, if the program of non-operative treatment fails, operative treatment is indicated when:

a. Improvement of the symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or

b. Frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence.

c. Mere passage of time with poorly guided treatment is not considered an active treatment program.

D. Surgical workup and implementation for simple decompression of patients with herniated nucleus pulposus and sciatica should occur within 6 to 12 weeks after injury at the latest, within the above stated contingencies. For patients with true, refractory mechanical low back pain in whom fusion is being considered, it is recommended that a decisive commitment to surgical or non-surgical interventions occur within 5 months following injury, at the latest.

E. Spinal decompression surgeries and fusion have re-operation rates of approximately 10 percent or more over the following five years. Re-operation is indicated only when the functional outcome following the re-operation is expected to be better, within a reasonable degree of certainty, than the outcome of other non-invasive or less invasive treatment procedures. "Functional outcomes" refer to the patient's ability to improve functional tolerances such as sitting, standing, walking, strength, endurance, and/or vocational status. While timely surgical decision-making is critical to avoid de-conditioning and increased disability, a time limited trial of reconditioning should be tried prior to re-operation. Re-operation has a high rate of complications and failure and may lead to disproportionately increased disability.

F. Every post-operative patient should be involved in an active treatment program. (Refer to Therapeutic Procedures-Non-Operative. Interdisciplinary interventions should be strongly considered post-operatively in any patient not making functional progress within expected time frames. (Refer to Interdisciplinary Programs.G. Return to work restrictions should be specific according to the recommendations in Section E. 10, Return to Work. Most non-fusion surgical patients can return to a limited level of duty between 3 to 6 weeks. Full activity is generally achieved between 6 weeks to 6 months depending on the procedure and healing of the individual.

1. Discectomy

a. Description: To enter into and partially remove the disc.

b. Complications: Appropriate medical disclosures should be provided to the patient as deemed necessary by the physician.

c. Surgical Indications: To include all of the following: Primary radicular symptoms, radiculopathy on exam, correlating imaging study, and failure of non-surgical care. There is good evidence that surgery provides initial improvement of radicular symptoms with respect to chronic low back pain. There is conflicting evidence that the long-term outcome differs from that of the natural history of healing.

d. Operative Treatment: Partial discectomy and root decompression.

e. Post-Operative Therapy: A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered.

## 2. Percutaneous discectomy

a. Description. Percutaneous discectomy is an invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications. Percutaneous discectomy is indicated only in cases of suspected septic discitis in order to obtain diagnostic tissue. The procedure is not recommended for contained disc herniations or bulges with associated radiculopathy due to lack of evidence to support long-term improvement.

d. Operative Treatment. Partial discectomy.

## 3. Laminotomy/laminectomy/foramenotomy/facetectomy

a. Description. These procedures provide access to produce neural decompression by partial or total removal of various parts of vertebral bone.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications include all of the following: Primary radicular symptoms, radiculopathy and radiculitis on exam, correlating imaging study, and failure of non-surgical care.

d. Operative Treatment. Laminotomy, and/or partial discectomy & root decompression.

e. Post-Operative Therapy: A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated 3-6 weeks post-operatively. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy.)

## 4. Spinal fusion

a. Description. Use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae.

b. Complications. Appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications. A timely decision-making process is recommended when considering patients for possible fusion. For chronic low back problems, fusion should not be considered within the first five months of symptoms, except for fracture or dislocation.

i. Although there is a statistical correlation between successful radiographic fusion and a good functional outcome, the relationship is not strong in the first two years. However, a recent observational study appears to indicate clinical deterioration in patients with unsuccessful radiographic fusion at an average of seven years post-operatively. There is good evidence that instrumented fusion, compared to non-instrumented fusion, produces a slightly better radiographically-confirmed bony union, with small to moderate functional advantages. Studies of surgical procedures report higher rates of complications with instrumented fusion.

ii. There is good evidence that intensive exercise for approximately 25 hours per week for four weeks combined with cognitive interventions emphasizing the benefits of maintaining usual activity, produces functional results similar to those of posterolateral fusion after one year. There is some evidence that lumbar fusion produces better symptomatic and functional results in patients with chronic non-radicular pain when several months of conservative treatment have not produced a satisfactory outcome. Fusions associated with decompression are more likely to reduce leg pain.

iii. Recombinant Human Bone Morphogenetic Protein (rhBMP-2) is a member of a family of cytokines capable of inducing bone formation. It is produced from genetically modified cell lines using molecular cloning techniques. At the time of this guideline writing, rhBMP-2 is FDA approved for use in anterior lumbar interbody fusion (ALIF) and is used with a carrier such as a collagen sponge or other matrix, and a cage. There is some evidence that anterior interbody cage fusion using rhBMP-2 results in shorter operative time compared with the use of iliac crest bone autograft. Minor pain at the iliac crest donor site may persist for 24 months or longer in approximately 30 percent of patients who undergo an autograft procedure. RhBMP-2 avoids the need for harvesting iliac crest donor bone and can therefore, avoid this complication of persistent pain. There is a potential for patients to develop sensitizing or blocking antibodies to rhBMP-2 or to the absorbable collagen sponge. The long-term effects are unknown. The rhBMP-2 used with the interbody fusion device is contraindicated for patients with a known hypersensitivity to Recombinant Human Bone Morphogenetic Protein -2, bovine type 1 collagen, or to other components of the formulation. Use of rhBMP-2 outside the anterior cage may carry a risk of swelling and ectopic bone formation which can encroach on neurovascular structures. At the time of this guideline writing, it is still investigational. Information concerning safe and effective dosing and application are being submitted

to the FDA. All other applications are considered off-label and not FDA approved. There is insufficient information to form a recommendation with instrumentation other than the cage specifically designed for anterior procedures. If the FDA approves its use for other operative approaches, prior authorization is required. The patient must meet all indications on the device manufacturer's list and have no contraindications. The formation of exuberant or ectopic bone growth at the upper levels (L2 - L4) may have a deleterious impact on certain neurovascular structures, such as the aorta and sympathetic nerve chain. There are also reports of osteoclastic activity with the use of rhBMP-2.

d. Indications for spinal fusion may include:

i. Neural arch defect – Spondylolytic spondylolisthesis, congenital unilateral neural arch hypoplasia.

ii. Segmental Instability - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability.

iii. Primary Mechanical Back Pain/Functional Spinal Unit Failure - Multiple pain generators objectively involving two or more of the following: (a) internal disc disruption (poor success rate if more than one disc involved), (b) painful motion segment, as in annular tears, (c) disc resorption, (d) facet syndrome, and or (e) ligamentous tear.

iv. Revision surgery for failed previous operation(s) if significant functional gains are anticipated.

v. Infection, tumor, or deformity of the lumbosacral spine that cause intractable pain, neurological deficit, and/or functional disability.

e. Pre-operative Surgical Indications: Required pre-operative clinical surgical indications for spinal fusion include all of the following:

i. All pain generators are adequately defined and treated; and

ii. All physical medicine and manual therapy interventions are completed; and

iii. X-ray, MRI, or CT/Discography demonstrate disc pathology or spinal instability; and

iv. Spine pathology is limited to two levels; and

v. Psychosocial evaluation with confounding issues addressed.

vi. For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

f. Operative Therapy: Operative procedures may include: a) Intertransverse Fusion; b) Anterior Fusion (with or without rhBMP-2) – generally used for component of discogenic pain where there is no significant radicular component requiring decompression; c) Posterior Interbody Fusion – generally used for component of discogenic pain where posterior decompression for radicular symptoms also performed; or d) Anterior/posterior (360°) Fusion – most commonly seen in unstable or potentially unstable situations or non-union of a previous fusion.

g.f. Post-operative Therapy: A formal physical therapy program should be implemented post-operatively.

Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic conditioning program (e.g., walking), and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes core stabilization, strengthening, and endurance is recommended to be initiated once the fusion is solid and without complication. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy).

h. Return-to-Work. Barring complications, patients responding favorably to spinal fusion may be able to return to sedentary-to-light work within 6 to 12 weeks post-operatively, light-to-medium work within six to nine months post-operatively and medium-to-medium/heavy work within 6 to 12 months post-operatively. Patients requiring fusion whose previous occupation involved heavy-to-very-heavy labor should be considered for vocational assessment as soon as reasonable restrictions can be predicted. The practitioner should release the patient with specific physical restrictions and should obtain a clear job description from the employer, if necessary. Once an injured worker is off work greater than six months, the functional prognosis with or without fusion becomes guarded for that individual.

#### 5. Sacroiliac joint fusion

a. Description. Use of bone grafts, sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae providing symptomatic instability as a part of major pelvic ring disruption.

b. Complications. Instrumentation failure, bone graft donor site pain, in-hospital mortality, deep infection, superficial infection, and graft extrusion.

c. Surgical Indications. Sacroiliac (SI) joint fusion may be indicated for stabilization of a traumatic severe disruption of the pelvic ring. This procedure has limited use in minor trauma and would be considered only on an individual case-by-case basis. In patients with typical mechanical low back pain, this procedure is considered to be investigational. Until the efficacy of this procedure for mechanical low back pain is determined by an independent valid prospective outcome study, this procedure is not recommended for mechanical low back pain.

6. Implantable spinal cord stimulators are reserved for those low back pain patients with pain of greater than six months duration who have not responded to the standard non-operative or operative interventions previously discussed within this document. Refer to OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

7. Laser discectomy involves the delivery of laser energy into the center of the nucleus pulposus using a fluoroscopically guided laser fiber under local anesthesia. The energy denatures protein in the nucleus, causing a structural change which is intended to reduce intradiscal pressure. Its effectiveness has not been shown. Laser discectomy is not recommended.

#### 8. Artificial lumbar disc replacement

a. Description. This involves the insertion of a prosthetic device into an intervertebral space from which a

degenerated disc has been removed, sparing only the peripheral annulus. The endplates are positioned under intraoperative fluoroscopic guidance for optimal placement in the sagittal and frontal planes. The prosthetic device is designed to distribute the mechanical load of the vertebrae in a physiologic manner and maintain range of motion.

i. General selection criteria for lumbar disc replacement includes symptomatic one-level degenerative disc disease. The patient must also meet fusion surgery criteria, and if the patient is not a candidate for fusion, a disc replacement procedure should not be considered. Additionally, the patient should be able to comply with pre- and post-surgery protocol.

ii. The theoretical advantage of total disc arthroplasty is that it preserves range of motion and physiologic loading of the disc. This could be an advantage for adults who are physically active. Studies do not demonstrate a long-term advantage of measured function or pain over comparison groups undergoing fusion. The longevity of this prosthetic device has not yet been determined. Significant technical training and experience is required to perform this procedure successfully. Surgeons must be well-versed in anterior spinal techniques and should have attended appropriate training courses, or have undergone training during a fellowship. Mentoring and proctoring of procedures is highly recommended. Reasonable pre-operative evaluation may include an angiogram to identify great vessel location. The angiogram may be either with contrast or with magnetic resonance imaging. An assistant surgeon with anterior access experience is required.

b. Complications:

- i. nerve and vascular injury;
- ii. dural tears;
- iii. sexual dysfunction (retrograde ejaculation);
- iv. mal-positioning of the prosthesis;
- v. suboptimal positioning of the prosthetic may compromise the long-term clinical result;
- vi. Complex Regional Pain Syndrome (CRPS);
- vii. complications from Abdominal Surgery, (e.g., hernia or adhesions);
- viii. re-operation due to complications;
- ix. appropriate medical disclosures should be provided to the patient as deemed necessary by the treating physician.

c. Surgical Indications

- i. Symptomatic one-level degenerative disc disease established by objective testing (CT or MRI scan followed by positive provocation discogram)
- ii. symptoms unrelieved after six months of active non-surgical treatment;
- iii. all pain generators are adequately defined and treated'
- iv. all physical medicine and manual therapy interventions are completed;
- v. spine pathology limited to one level;
- vi. psychosocial evaluation with confounding issues addressed;

d. Contraindications

- i. significant spinal deformity/scoliosis;
- ii. facet joint arthrosis;
- iii. spinal instability;

- iv. deficient posterior elements;
- v. infection;
- vi. any contraindications to an anterior abdominal approach (including multiple prior abdominal procedures);
- vii. evidence of nerve root compression, depending on the device used;
- viii. previous compression or burst fracture ;
- ix. multiple-level degenerative disc disease (DDD);
- x. spondylolysis;
- xi. spondylolisthesis greater than 3 mm;
- xii. osteoporosis or any metabolic bone disease;
- xiii. chronic steroid use or use of other medication known to interfere with bone or soft tissue healing;
- xiv. autoimmune disorder;
- xv. allergy to device components/materials;
- xvi. depending on the device selected, pregnancy or desire to become pregnant;
- xvii. morbid obesity (e.g., body/mass index [BMI] of greater than 40, over 100 pounds overweight);
- xviii. active malignancy;

e. Post-operative Therapy. Bracing may be appropriate. A formal physical therapy program should be implemented post-operatively. Active treatment, which patients should have had prior to surgery, will frequently require a repeat of the sessions previously ordered. The implementation of a gentle aerobic reconditioning program (e.g., walking) and back education within the first post-operative week is appropriate in uncomplicated post-surgical cases. Some patients may benefit from several occupational therapy visits to improve performance of ADLs. Participation in an active therapy program which includes restoration of ROM, core stabilization, strengthening, and endurance is recommended to be initiated at the discretion of the surgeon. Lifting and bending are usually limited for several months at least. Sedentary duty may be able to begin within six weeks in uncomplicated cases. The goals of the therapy program should include instruction in a long-term home based exercise program. (Refer to Active Therapy.)

8. Kyphoplasty

a. Description. A surgical procedure for the treatment of symptomatic thoracic or lumbar vertebral compression fractures, most commonly due to osteoporosis or other metabolic bone disease, and occasionally with post-traumatic compression fractures and minor burst fractures that do not significantly compromise the posterior cortex of the vertebral body. Pain relief can be expected in approximately 90 percent of patients. Vertebral height correction is inconsistent, with approximately 35 percent to 40 percent of procedures failing to restore height or kyphotic angle.

b. Complications: Cement leakage occurs in approximately nine percent of kyphoplasties and may cause complications. New vertebral compression fracture may occur following kyphoplasty, but their occurrence does not appear to exceed that of osteoporotic patients who did not receive treatment.

c. Operative Treatment: Kyphoplasty involves the percutaneous insertion of a trocar and inflatable balloon or expanding polymer into the vertebral body, which re-expands the body, elevating the endplates and reducing the compression deformity. Polymethylmethacrylate (PMMA)

bone cement is injected under low pressure into the cavity created by the balloon inflation. In contrast to vertebroplasty, which introduces PMMA cement under high pressure, the space created by balloon inflation allows a higher viscosity PMMA to be injected under lower pressure, which may reduce the risks associated with extravertebral extravasation of the material. There may be an advantage to performing the procedure within one month of the fracture, since the elevation of the endplates may be more readily achieved than when the procedure is delayed.

d. Surgical Indications. Kyphoplasty is an accepted treatment for the following indications:

- i. compression fracture ;
- ii. vertebral height loss between 20 percent and 85 percent;
- iii. vertebral height restoration. Kyphoplasty is more likely to increase vertebral height if performed within 30 days of fracture occurrence.

e. Contraindications

- i. the presence of neurologic compromise related to fracture;
- ii. high-velocity fractures with a significant burst component;
- iii. significant posterior vertebral body wall fracture;
- iv. severe vertebral collapse (vertebra plana);
- v. infection, and
- vi. coagulopathy .

9. Vertebroplasty

a. Description Vertebroplasty is a procedure for the treatment of painful thoracic and lumbar vertebral compression fractures caused by osteoporosis or other metabolic bone disease. Polymethylmethacrylate (PMMA) bone cement is injected with high pressure into the vertebral body via an 11- to 13-gauge needle, with the goal of stabilizing the spine and relieving pain. The procedure does not correct spinal deformity. Pain relief can be expected in approximately 90 percent of patients. Vertebral height correction is inconsistent, with approximately 35 percent to 40 percent of procedures failing to restore height or kyphotic angle.

b. Complications

i. Because the bone cement is of low viscosity, its injection under pressure frequently results in extravertebral extravasation of the material, with rare serious complications such as pulmonary embolism. Cement leakage alone occurs in approximately 40 percent of vertebroplasties.

ii. New vertebral compression fractures may occur following vertebroplasty, but their occurrence does not appear to exceed that of osteoporotic patients who did not receive treatment.

c. Indications

- i. compression fracture of preferably less than 30 days;
- ii. vertebral height loss between 20 percent and 85 percent;
- iii. intact posterior wall;

d. Contraindications

i. the presence of neurologic compromise related to the fracture;

- ii. high velocity fractures with a significant burst component;
- iii. posterior vertebral body wall fracture;
- iv. severe vertebral collapse (vertebra plana); and
- v. infection; and
- vi. coagulopathy

10. Percutaneous radiofrequency disc decompression is an investigational procedure which introduces a 17 gauge cannula under local anesthesia and fluoroscopic guidance into the nucleus pulposus of the contained herniated disc, using radiofrequency energy to dissolve and remove disc material. Pressure inside the disc is lowered as a result. There have been no randomized clinical trials of this procedure at this time. Percutaneous radiofrequency disc decompression is not recommended.

11. Nucleus pulposus replacement involves the introduction of a prosthetic implant into the intervertebral disc, replacing the nucleus while preserving the annulus fibrosus. It is limited to investigational use in the United States at this time. It is not recommended.

12. Epiduroscopy and Epidural Lysis of Adhesions (Refer to Injections-Therapeutic).

13. Intraoperative Monitoring is a common intraoperative electrodiagnostic technique that may include somatosensory evoked potentials (SSEP), motor evoked potentials (MEP), or pedicle screw monitoring. The monitoring procedure may be used at the discretion of the physician. The use of intraoperative monitoring can be anticipated to become more common as percutaneous spinal procedures gain greater acceptance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2024. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:

OWCA—Medical Services  
 ATTN: Medical Director  
 P.O. Box 94040  
 Baton Rouge, LA 70804

- 1. Social Security No. \_ \_ - \_ -
- 2. Date of Injury/Illness \_ - - \_ -
- 3. Parts of Body Injury \_\_\_\_\_
- 4. Date of Birth \_ - - \_ -
- 5. Date of This Request \_ - - \_ -
- 6. Claim Number \_\_\_\_\_

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by  
 \_\_\_ Employee \_\_\_ Employer \_\_\_ Insurer \_\_\_ Health Care Provider \_\_\_  
 Other \_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.



includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-evaluation treatment every three to four weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return-to-Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to

make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10% of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. "Consensus" means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. "Some" means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. "Good" means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. "Strong" means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2105. Introduction to Chronic Pain**

A. The International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience with actual or potential tissue damage." Pain is a complex experience embracing physical, mental, social, and behavioral processes that often compromises the quality of life of many individuals. Pain is an unpleasant subjective perception usually in the context of tissue damage.

B. Pain is subjective and cannot be measured or indicated objectively. Pain evokes negative emotional reactions such as fear, anxiety, anger, and depression. People usually regard pain as an indicator of physical harm, despite the fact that pain can exist without tissue damage and tissue damage can exist without pain. Many people report pain in the absence of tissue damage or any likely pathophysiologic cause. There is no way to distinguish their experience from that due to actual tissue damage. If they regard their experience as pain and they report it the same way as pain caused by tissue damage, it should be accepted as pain.

C. Pain can generally be classified as:

1. Nociceptive which includes pain from visceral origins or damage to other tissues. Myofascial pain is a nociceptive type of pain characterized by myofascial trigger points limited to a specific muscle or muscles.

2. Neuropathic including that originating from brain, peripheral nerves or both;

3. Psychogenic that originates in mood, characterological, social, or psychophysiological processes.

D. Recent advances in the neurosciences reveal additional mechanisms involved in chronic pain. In the past, pain was seen as a sensation arising from the stimulation of pain receptors by damaged tissue, initiating a sequence of nerve signals ending in the brain and there recognized as pain. A consequence of this model was that ongoing pain following resolution of tissue damage was seen as less physiological and more psychological than acute pain with identifiable tissue injury. Current research indicates that chronic pain involves additional mechanisms that cause: neural remodeling at the level of the spinal cord and higher levels of the central nervous system; changes in membrane responsiveness and connectivity leading to activation of larger pain pathways; and recruitment of distinct neurotransmitters.

E. Changes in gene function and expression may occur, with lasting functional consequences. These physiologic functional changes cause chronic pain to be experienced in body regions beyond the original injury and to be exacerbated by little or no stimulation. The chronic pain experience clearly represents both psychologic and complex physiologic mechanisms, many of which are just beginning to be understood.

F. Chronic Pain is defined as "pain that persists for at least 30 days beyond the usual course of an acute disease or a reasonable time for an injury to heal or that is associated with a chronic pathological process that causes continuous pain (e.g., reflex sympathetic dystrophy)." The very definition of chronic pain describes a delay or outright failure to relieve pain associated with some specific illness or accident. Delayed recovery should prompt a clinical review of the case and a psychological evaluation by the health care provider. Referral to a recognized pain specialist for further evaluation is recommended. Consideration may be given to new diagnostic testing or a change in treatment plan.

G. Use of the term "chronic pain syndrome" has been used and defined in a variety of ways that generally indicate a belief on the part of the health care provider that the patient's pain is inappropriate or out of proportion to existing problems or illness. Use of the term "chronic pain syndrome" should be discontinued because the term ceases to have meaning due to the many different physical and psychosocial issues associated with it. Instead, practitioners should use the nationally accepted terminology indicated in the definition section and/or the psychiatric diagnosis of "Pain Disorder" and the subtypes according to established standards of the American Psychiatric Association (APA).

H. The IASP offers taxonomy of pain, which underscores the wide variety of pathological conditions associated with chronic pain. This classification system may not address the psychological and psychosocial issues that occur in the perception of pain, suffering, and disability and may require

referral to psychiatric or psychological clinicians. These issues should be documented with preference to the diagnostic categories of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association including the subcategories of pain disorder and any other applicable diagnostic categories (i.e., depressive, anxiety, and adjustment disorders).

I. Chronic pain is a phenomenon not specifically relegated to anatomical or physiologic parameters. The prevailing biomedical model (which focuses on identified disease pathology as the sole cause of pain) cannot capture all of the important variables in pain behavior. While diagnostic labels may pinpoint contributory physical and/or psychological factors and lead to specific treatment interventions that are helpful, a large number of patients defy precise taxonomic classification. Furthermore, such diagnostic labeling often overlooks important social contributions to the chronic pain experience. Failure to address these operational parameters of the chronic pain experience may lead to incomplete or faulty treatment plans. The term "pain disorder" is perhaps the most useful term in the medical literature today, in that it captures the multifactorial nature of the chronic pain experience.

J. It is recognized that some health care practitioners, by virtue of their experience, additional training, and/or accreditation by pain specialty organizations, have much greater expertise in the area of chronic pain evaluation and treatment than others. Referrals for the treatment of chronic pain should be to such recognized specialists. Chronic pain treatment plans should be monitored and coordinated by pain medicine physicians with such specialty training, in conjunction with other health care specialists.

K. Most acute and some chronic pain problems are adequately addressed in other OWCA treatment guidelines, and are generally beyond the scope of these guidelines. However, because chronic pain is more often than not multifactorial, involving more than one pathophysiologic or mental disorder, some overlap with other guidelines is inevitable. These guidelines are meant to apply to any patient who fits the operational definition of chronic pain discussed at the beginning of this section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2107. Definitions**

A. Aftersensation refers to the abnormal persistence of a sensory perception, provoked by a stimulus even though the stimulus has ceased.

B. Allodynia is pain due to a non-noxious stimulus that does not normally provoke pain.

1. Mechanical Allodynia refers to the abnormal perception of pain from usually non-painful mechanical stimulation.

2. Static Mechanical Allodynia – Refers to pain obtained by applying a single stimulus such as light pressure to a defined area.

3. Dynamic Mechanical Allodynia – Obtained by moving the stimulus such as a brush or cotton tip across the abnormal hypersensitive area.

4. Thermal Allodynia – Refers to the abnormal sensation of pain from usually non-painful thermal stimulation such as cold or warmth.

C. Analgesia. Absence of pain in response to stimulation that would normally be painful.

D. Biopsychosocial . A term that reflects the multiple facets of any clinical situation; namely, the biological, psychological, and social situation of the patient.

E. Central pain. Pain initiated or caused by a primary lesion or dysfunction in the central nervous system.

F. Central sensitization. The experience of pain evoked by the excitation of non-nociceptive neurons or of nerve fibers that normally relay non-painful sensations to the spinal cord. This results when non-nociceptive afferent neurons act on a sensitized central nervous system (CNS).

G. Dysesthesia. An abnormal sensation described by the patient as unpleasant. As with paresthesia, dysesthesia may be spontaneous or evoked by maneuvers on physical examination.

H. Hyperalgesia. Refers to an exaggerated pain response from a usually painful stimulation.

I. Hyperesthesia (positive sensory phenomena. Includes allodynia, hyperalgesia, and hyperpathia. Elicited by light touch, pin prick, cold, warm, vibration, joint position sensation or two-point discrimination, which is perceived as increased or more.

J. Hyperpathia. Refers to an abnormally painful and exaggerated reaction to stimulus, especially to a repetitive stimulus.

K. Hypoalgesia. Diminished pain perception in response to a normally painful stimulus.

L. Hypoesthesia (negative sensory phenomena). Refers to a stimulus such as light touch, pin prick, cold, point position sensation, two-point discrimination, or sensory neglect which is perceived as decreased.

M. Malingering. Intentional feigning of illness or disability in order to escape work or gain compensation.

N. Myofascial Pain. A regional pain characterized by tender points in taut bands of muscle that produce pain in a characteristic reference zone.

O. Myofascial Trigger Point. A physical sign in a muscle which includes, exquisite tenderness in a taut muscle band; and referred pain elicited by mechanical stimulation of the trigger point. The following findings may be associated with myofascial trigger points: Local twitch or contraction of the taut band when the trigger point is mechanically stimulated; Reproduction of the patient's spontaneous pain pattern when the trigger point is mechanically stimulated; Weakness without muscle atrophy; Restricted range of motion of the affected muscle; and Autonomic dysfunction associated with the trigger point such as changes in skin or limb temperature.

P. Neuralgia . Pain in the distribution of a nerve or nerves.

Q. Neuritis. Inflammation of a nerve or nerves.

R. Neurogenic pain. Pain initiated or caused by a primary lesion, dysfunction, or transitory perturbation in the peripheral or central nervous system.

S. Neuropathic pain. Pain due to an injured or dysfunctional central or peripheral nervous system.

T. Neuropathy. A disturbance of function or pathological change in a nerve: in one nerve, mononeuropathy; in several

nerves, mononeuropathy multiplex; if diffuse and bilateral, polyneuropathy.

U. Nociceptor. A receptor preferentially sensitive to a noxious stimulus or to a stimulus which would become noxious if prolonged.

V. Pain behavior. The non-verbal actions (such as grimacing, groaning, limping, using visible pain relieving or support devices and requisition of pain medications, among others) that are outward manifestations of pain, and through which a person may communicate that pain is being experienced.

W. Pain threshold. The smallest stimulus perceived by a subject as painful.

X. Paresthesia. An abnormal sensation that is not described as pain. It can be either a spontaneous sensation (such as pins and needles) or a sensation evoked from non-painful or painful stimulation, such as light touch, thermal, or pinprick stimulus on physical examination.

Y. Peripheral neurogenic pain. Pain initiated or caused by a primary lesion or dysfunction or transitory perturbation in the peripheral nervous system.

Z. Peripheral neuropathic pain. Pain initiated or caused by a primary lesion or dysfunction in the peripheral nervous system.

AA. Summation. Refers to abnormally painful sensation to a repeated stimulus although the actual stimulus remains constant. The patient describes the pain as growing and growing as the same intensity stimulus continues.

BB. Sympathetically maintained pain (smp). A pain that is maintained by sympathetic efferent innervations or by circulating catecholamines.

CC. Tender points. Tenderness on palpation at a tendon insertion, muscle belly or over bone. Palpation should be done with the thumb or forefinger, applying pressure approximately equal to a force of four kilograms (blanching of the entire nail bed).

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2109. Initial Evaluation & Diagnostic Procedures**

A. The OWCA recommends the following diagnostic procedures be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures that should be utilized when initially diagnosing a work-related chronic pain complaint are listed below.

1. History and Physical Examination (Hx & PE).

a. Medical History. As in other fields of medicine, a thorough patient history is an important part of the evaluation of chronic pain. In taking such a history, factors influencing a patient's current status can be made clear and taken into account when planning diagnostic evaluation and treatment. One efficient manner in which to obtain historical information is by using a questionnaire. The questionnaire may be sent to the patient prior to the initial visit or administered at the time of the office visit. The following items are considered essential history:

i general information—General items requested are name, sex, age, birth date, etc;

ii. level of education—the level of patient's education may influence response to treatment;

iii. work history/occupation—to include both impact of injury on job duties and impact on ability to perform job duties, work history, job description, mechanical requirements of the job, duration of employment, and job satisfaction;

iv. current employment status;

v. marital status;

vi. family environment—Is the patient living in a nuclear family or with friends? Is there or were there, any family members with chronic illness or pain problems? Responses to such questions reveal the nature of the support system or the possibility of conditioning toward chronicity;

vii. ethnic origin—Ethnicity of the patient, including any existing language barriers, may influence the patient's perception of and response to pain. There is evidence that providers may under-treat patients of certain ethnic backgrounds due to underestimation of their pain;

viii. belief system—The patient may refuse various treatments or may have an altered perception of his pain due to his particular beliefs;

ix. activities of daily living—Pain has a multidimensional effect on the patient that is reflected in changes in usual daily vocational, social, recreational, and sexual activities;

x. past and present psychological problems;

xi. history of abuse—physical, emotional, sexual;

xii. history of disability in the family;

xiii. sleep disturbances

b. Pain History. Characterization of the patient's pain and of the patient's response to pain is one of the key elements in treatment.

i. site of pain—localization and distribution of the pain help determine the type of pain the patient has (i.e., central versus peripheral);

ii. pain drawing/Visual Analog Scale (VAS);

iii. duration;

iv. place of onset;

v. pain characteristics—time of pain occurrence as well as intensity, quality and radiation give clues to the diagnosis and potential treatment;

vi. response of pain to activity;

vii. associated symptoms—Does the patient have numbness or paresthesia, dysesthesia, weakness, bowel or bladder dysfunction, decreased temperature, increased sweating, cyanosis or edema? Is there local tenderness, allodynia, hyperesthesia, or hyperalgesia?

c. Medical Management History.

i. prior treatment—What has been tried and which treatments have helped?;

ii. prior surgery—If the patient has had prior surgery specifically for the pain, he/she is less likely to have a positive outcome;

iii. medications—History of and current use of medications, including over the counter and herbal/dietary supplements to determine drug usage (or abuse) interactions and efficacy of treatment;

iv. review of systems check list—Determine if there is any interplay between the pain complaint and other medical conditions;

v. psychosocial functioning—Determine if the following are present: current symptoms of depression or anxiety, evidence of stressors in the workplace or at home, and past history of psychological problems. It is recommended that patients diagnosed with Chronic Pain be referred for a psychosocial evaluation;

vi. diagnostic tests—All previous radiological and laboratory investigations should be reviewed;

vii. pre-existing conditions—Treatment of these conditions is appropriate when the pre-existing condition affects recovery from chronic pain.

d. Substance use/abuse

i. alcohol use;

ii. smoking history;

iii. history of drug use and abuse;

iv. caffeine or caffeine-containing beverages;

e. Other factors affecting treatment outcome

i. compensation/disability/litigation;

ii. treatment expectations—what does the patient expect from treatment: complete relief of pain or reduction to a more tolerable level?

f. Physical Examination

i. Neurologic Evaluation—Cranial nerves, muscle tone and strength, atrophy, upper motor neuron signs, motor evaluation reflexes, and provocative neurological maneuvers.

ii. Sensory Evaluation—A detailed sensory examination is crucial in evaluating a patient with chronic pain complaints. Quantitative sensory testing, such as Semmes-Weinstein, may be useful tools in determining sensory abnormalities. The examination should determine if the following sensory signs are present:

(a). Hyperalgesia;

(b). Hyperpathia;

(c). Paresthesia;

(d). Dysesthesia;

(e). Mechanical Allodynia – static versus dynamic

(f). Thermal Allodynia

(g). Hypoesthesia

(h). Hyperesthesia

(i). Summation

iii. Musculoskeletal Evaluation – Range of motion, segmental mobility, musculoskeletal provocative maneuvers, palpation, observation, and functional activities. All joints, muscles, ligaments, and tendons should be examined for swelling, laxity, and tenderness. A portion of the musculoskeletal evaluation is the myofascial examination. The myofascial examination includes palpating soft tissues for evidence of tightness and trigger points;

iv. evaluation of nonphysiologic findings

(a). Waddell's nonorganic findings including, superficial or nonorganic tenderness; pseudo maneuvers; discrepant straight leg raise; nonanatomic sensory and/or motor examination; and overreaction: collapsing, tremor, pain behavior, muscle tension.

(b). Variabilities on formal exam including variable sensory exam, inconsistent tenderness, and/or swelling secondary to extrinsic sources.

(c). Inconsistencies between formal exam and observed abilities of range of motion, motor strength, gait and cognitive/emotional state.

(d). Observation of consistencies between pain behavior, affect and verbal pain rating, and affect and physical re-examination.

## 2. Personality/Psychosocial/Psychiatric/ Psychological Evaluation

a. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychiatric/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- i. employment history;
- ii. interpersonal relationships-both social and work;
- iii. patient activities;
- iv. current perception of the medical system;
- v. current perception/attitudes toward employer/job;
- vi. results of current treatment;
- vii. risk factors and psychological comorbidities that may influence outcome and that may require treatment;
- viii. childhood history, including history of childhood psychological trauma, abuse and family history of disability.

b. Personality/psychological/psychiatric/psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of

the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

i. Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

(a). Clinical Evaluation: All chronic pain patients should have a clinical evaluation that addresses the following areas:

(i). History of Injury – The history of the injury should be reported in the patient’s words or using similar terminology. Caution must be exercised when using translators.

- [a]. nature of injury;
- [b]. psychosocial circumstances of the injury;
- [c]. current symptomatic complaints;
- [d]. extent of medical corroboration;
- [e]. treatment received and results;
- [f]. compliance with treatment;
- [g]. coping strategies used, including perceived locus of control;
- [h]. perception of medical system and employer;
- [i]. history of response to prescription medications.

(ii). Health History

- [a]. nature of injury;
- [b]. medical history;
- [c]. psychiatric history;
- [d]. history of alcohol or substance abuse;
- [e]. activities of daily living;
- [f]. mental status exam;
- [g]. previous injuries, including disability, impairment, and compensation

(iii). Psychosocial history

- [a]. childhood history, including abuse;
- [b]. educational history;
- [c]. family history, including disability;
- [d]. marital history and other significant adulthood activities and events;
- [e]. legal history, including criminal and civil litigation;
- [f]. employment and military history;
- [g]. signs of pre-injury psychological dysfunction;

[h]. current interpersonal relations, support, living situation;

- [i]. financial history
- (iv). Psychological test results, if performed
- (v). Danger to self or others.
- (vi). Current psychiatric diagnosis consistent with the standards of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

(vii). Pre-existing psychiatric conditions. Treatment of these conditions is appropriate when the pre-existing condition affects recovery from chronic pain.

(viii). Causality (to address medically probable cause and effect, distinguishing pre-existing

psychological symptoms, traits and vulnerabilities from current symptoms).

(ix). Treatment recommendations with respect to specific goals, frequency, timeframes, and expected outcomes.

(b). Tests of Psychological Functioning: Psychometric Testing is a valuable component of a consultation to assist the physician in making a more effective treatment plan. Psychometric testing is useful in the assessment of mental conditions, pain conditions, cognitive functioning, treatment planning, vocational planning, and evaluation of treatment effectiveness. There is no general agreement as to which standardized psychometric tests should be specifically recommended for psychological evaluations of chronic pain conditions. It is appropriate for the mental health provider to use their discretion and administer selective psychometric tests within their expertise and within standards of care in the community. Some of these tests are available in Spanish and other languages, and many are written at a sixth grade reading level. Examples of frequently used psychometric tests performed include, but not limited to, the following.

(i). Comprehensive Inventories for Medical Patients

[a]. Battery for Health Improvement, 2nd Edition (BHI-2) . What it measures – Depression, anxiety and hostility; violent and suicidal ideation; borderline, dependency, chronic maladjustment, substance abuse, conflicts with work, family and physician, pain preoccupation, somatization, perception of functioning and others. Benefits – When used as a part of a comprehensive evaluation, can contribute substantially to the understanding of psychosocial factors underlying pain reports, perceived disability, somatic preoccupation, and help to design interventions. Serial administrations can track changes in a broad range of variables during the course of treatment, and assess outcome.

[b]. Millon Behavioral Medical Diagnostic (MBMD) . What it Measures – Updated version of the Millon Behavioral Health Inventory (MBHI). Provides information on Coping Styles (introverted, inhibited, dejected, cooperative, sociable, etc), Health Habits (smoking, drinking, eating, etc.), Psychiatric Indications (anxiety, depression, etc), stress moderators (Illness Apprehension vs. Illness Tolerance, etc), treatment prognostics (Interventional Fragility vs. Interventional Resilience, Medication Abuse vs. Medication Competence, etc) and other factors. Benefits – When used as a part of a comprehensive evaluation, can contribute substantially to the understanding of psychosocial factors affecting medical patients. Understanding risk factors and patient personality type can help to optimize treatment protocols for a particular patient.

[c]. Pain Assessment Battery (PAB). What it measures – Collection of four separate measures that are administered together. Emphasis on the assessment of pain, coping strategies, degree and frequency of distress, health-related behaviors, coping success, beliefs about pain, quality of pain experience, stress symptoms analysis, and others. Benefits—When used as a part of a comprehensive evaluation, can contribute substantially to the understanding of patient stress, pain reports and pain coping strategies, and

help to design interventions. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome.

ii. Comprehensive Psychological Inventories. These tests are designed for detecting various psychiatric syndromes, but in general are more prone to false positive findings when administered to medical patients.

(a). Millon Clinical Multiaxial Inventory, 3rd Edition (MCMI-III). What it measures – Has scales based on DSM diagnostic criteria for affective, personality, and psychotic disorders and somatization. Benefits – When used as a part of a part of a comprehensive evaluation, can screen for a broad range of DSM diagnoses.

(b). Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2). What it measures – Original scale constructs, such as hysteria and psychesthesia are archaic but continue to be useful. Newer content scales include depression, anxiety, health concerns, bizarre mentation, social discomfort, low self-esteem, and almost 100 others. Benefits – When used as a part of a comprehensive evaluation, measure a number of factors that have been associated with poor treatment outcome.

(c). Personality Assessment Inventory (PAI). What it measures – A good measure of general psychopathology. Measures depression, anxiety, somatic complaints, stress, alcohol and drug use reports, mania, paranoia, schizophrenia, borderline, antisocial, and suicidal ideation and more than 30 others. Benefits – When used as a part of a comprehensive evaluation, can contribute substantially to the identification of a wide variety of risk factors that could potentially affect the medical patient.

iii. Brief Multidimensional Screens for Medical Patients. Treating providers, to assess a variety of psychological and medical conditions, including depression, pain, disability and others, may use brief instruments. These instruments may also be employed as repeated measures to track progress in treatment, or as one test in a more comprehensive evaluation. Brief instruments are valuable in that the test may be administered in the office setting and hand scored by the physician. Results of these tests should help providers distinguish which patients should be referred for a specific type of comprehensive evaluation.

(a). Brief Battery for Health Improvement, 2nd Edition (BBHI-2). What it measures – Depression, anxiety, somatization, pain, function, and defensiveness. Benefits – Can identify patients needing treatment for depression and anxiety, and identify patients prone to somatization, pain magnification and self-perception of disability. Can compare the level of factors above to other pain patients and community members. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome.

(b). Multidimensional Pain Inventory (MPI). What it measures – Interference, support, pain severity, life-control, affective distress, response of significant other to pain, and self-perception of disability at home and work, and in social and other activities of daily living. Benefits – Can identify patients with high levels of disability perceptions, affective distress, or those prone to pain magnification. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome.

(c). Pain Patient Profile (P3). What it measures – Assesses depression, anxiety, and somatization. Benefits – Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety and somatization to other pain patients and community members. Serial administrations can track changes in measured variables during the course of treatment, and assess outcome.

(d). SF-36®. What it measures – A survey of general health well-being and functional states. Benefits – Assesses a broad spectrum of patient disability reports. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome.

(e). Sickness Impact Profile (SIP). What it measures—Perceived disability in the areas of sleep, eating, home management, recreation, mobility, body care, social interaction, emotional behavior, and communication. Benefits – Assesses a broad spectrum of patient disability reports. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome.

(f). McGill Pain Questionnaire (MPQ). What it measures – Cognitive, emotional and sensory aspects of pain. Benefits – Can identify patients prone to pain magnification. Repeated administrations can track progress in treatment for pain.

(g). McGill Pain Questionnaire – Short Form (MPQ-SF). What it measures – Emotional and sensory aspects of pain. Benefits – Can identify patients prone to pain magnification. Repeated administrations can track progress in treatment for pain.

(h). Oswestry Disability Questionnaire. What it measures – Disability secondary to low back pain. Benefits – Can measure patients' self-perceptions of disability. Serial administrations could be used to track changes in self-perceptions of functional ability during the course of treatment, and assess outcome.

(i). Visual Analog Scales (VAS). What it measures – Graphical measure of patient's pain report. Benefits – Quantifies the patients' pain report. Serial administrations could be used to track changes in pain reports during the course of treatment and assess outcome.

iv. Brief Multidimensional Screens for Psychiatric Patients. These tests are designed for detecting various psychiatric syndromes, but in general are more prone to false positive findings when administered to medical patients.

(a). Brief Symptom Inventory. What it measures: Somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoia, psychoticism, and interpersonal sensitivity. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety, and somatization to community members. Serial administrations could be used to track changes in measured variables during the course of treatment, and assess outcome.

(b). Brief Symptom Inventory – 18 (BSI-18). What it Measures: Depression, anxiety, somatization. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to

somatization. Can compare the level of depression, anxiety, and somatization to community members. Serial administrations could be used to track patient perceived functional changes during the course of treatment, and assess outcome.

(c). Symptom Check List 90 (SCL 90). What it measures: Somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, paranoia, psychoticism, and interpersonal sensitivity. Benefits: Can identify patients needing treatment for depression and anxiety, as well as identify patients prone to somatization. Can compare the level of depression, anxiety and somatization to community members. Serial administrations could be used to track changes in measured variables during the course of treatment, and assess outcome.

v. Brief Specialized Psychiatric Screening Measures

(a). Beck Depression Inventory (BDI). What it measures: Depression. Benefits: Can identify patients needing referral for further assessment and treatment for depression and anxiety, as well as identify patients prone to somatization. Repeated administrations can track progress in treatment for depression, anxiety, and somatic preoccupation.

(b). Post Traumatic Stress Diagnostic Scale (PDS)

What it Measures: Post Traumatic Stress Disorder (PTSD). Benefits: Helps confirm suspected PTSD diagnosis. Repeated administrations can track treatment progress of PTSD patients.

(c). Center of Epidemiologic Studies – Depression Questionnaire. What it measures: Depression. Benefits: Brief self-administered screening test. Requires professional evaluation to verify diagnosis.

(d). Brief Patient Health Questionnaire from PRIME - MD. What it measures: Depression, panic disorder. Benefits: Brief self-administered screening test. Requires professional evaluation to verify diagnosis.

(e). Zung Questionnaire. What it measures: Depression. Benefits: Brief self-administered screening test. Requires professional evaluation to verify diagnosis.

(f) Diagnostic Studies. Imaging of the spine and/or extremities is a generally accepted, well-established, and widely used diagnostic procedure when specific indications, based on history and physical examination, are present. Physicians should refer to individual OWCA guidelines for specific information about specific testing procedures.

(g). Radiographic Imaging. MRI, CT, bone scan, radiography, SPECT and other special imaging studies may provide useful information for many musculoskeletal disorders causing chronic pain. Single Photon Emission Computerized Tomography (SPECT): A scanning technique which may be helpful to localize facet joint pathology and is useful in determining which patients are likely to have a response to facet injection. SPECT combines bone scans & CT Scans in looking for facet joint pathology.

(h). Electrodiagnostic studies may be useful in the evaluation of patients with suspected myopathic or neuropathic disease and may include Nerve Conduction Studies (NCS), Standard Needle Electromyography, or Somatosensory Evoked Potential (SSEP). The evaluation of

electrical studies is difficult and should be relegated to specialists who are well trained in the use of this diagnostic procedure.

(i). Special Testing Procedures may be considered when attempting to confirm the current diagnosis or reveal alternative diagnosis. In doing so, other special tests may be performed at the discretion of the physician.

(j). Testing for complex regional pain syndrome (CRPS-I) or sympathetically maintained pain (SMP) is described in the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.

4. Laboratory testing is generally accepted well-established and widely used procedures and can provide useful diagnostic and monitoring information. They may be used when there is suspicion of systemic illness, infection, neoplasia, or underlying rheumatologic disorder, connective tissue disorder, or based on history and/or physical examination. Tests include, but are not limited to:

a. Complete Blood Count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;

b. Erythrocyte sedimentation rate, rheumatoid factor, antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder;

c. Thyroid, glucose and other tests to detect endocrine disorders;

d. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease;

e. Urinalysis to detect bacteria (usually with culture and sensitivity), calcium, phosphorus, hydroxyproline, or hematuria;

f. Liver and kidney function may be performed for baseline testing and monitoring of medications; and

g. Toxicology Screen and/or Blood Alcohol Level if suspected drug or alcohol abuse.

#### 5. Injections-Diagnostic

##### a. Spinal Diagnostic Injections:

i. Description — generally accepted, well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information indicating strong suspicion for pathologic condition(s) and the source of pain symptoms.

(a). Because injections are invasive with an inherent risk, the number of diagnostic procedures should be limited in any individual patient to those most likely to be primary pain generators. Patients should not receive all of the diagnostic blocks listed merely in an attempt to identify 100 percent of the pain generators. The interpretation of the test results are primarily based on functional change, symptom report, and pain response (via a recognized pain scale before and at an appropriate time after the injection).

The diagnostic significance of the test result should be evaluated in conjunction with clinical information and the results of other diagnostic procedures. Injections with local anesthetics of differing duration may be used to support a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose cervical conditions. Refer to Injections – Therapeutic for information on specific injections. It is obligatory that sufficient data be accumulated by the examiner performing this procedure such that the diagnostic value of the procedure is evident to other reviewers. This entails, at a minimum, documentation of patient response immediately following the procedure with details of any symptoms with a response and the degree of response. Additionally, a log must be recorded as part of the medical record which documents response, if any, on an hourly basis for, at a minimum, the expected duration of the local anesthetic phase of the procedure. Responses must be identified as to specific body part (e.g., low back, neck, leg, or arm pain). The practitioner must identify the local anesthetic used and the expected duration of response for diagnostic purposes. Multiple injections provided at the same session without staging may seriously dilute the diagnostic value of these procedures. Practitioners must carefully weigh the diagnostic value of the procedure against the possible therapeutic value.

ii. Special Requirements for Diagnostic Injections. Since multi-planar, fluoroscopy during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement for all spinal procedures. The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner who performs spinal injections for low back pain should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. The practitioner who performs spinal injections for cervical pain should have completed fellowship training in pain medicine with interventional training, or its equivalent. Practitioners performing spinal injections for low back and cervical pain must also be knowledgeable in radiation safety.

iii. Complications. General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningeal abscess. Severe complications of cervical injections are remote but can include spinal cord damage, quadriplegia, and/or death. Injections at a C2-C3 level frequently cause temporary neuritis with ataxia.

iv. Contraindications. Absolute contraindications to diagnostic injections include: bacterial infection, systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy. Relative contraindications of diagnostic injections may include, allergy to contrast or shellfish, poorly controlled Diabetes Mellitus or and hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a

knowledgeable specialist. It is recommended to refer to Am Society of Regional Anesthesia for anticoagulation guidelines.

v. Specific Diagnostic Injections. In general, relief should last for at least the duration of the local anesthetic used and should significantly relieve pain and result in functional improvement. Refer to Therapeutic Injections for information on other specific therapeutic injections. The following injections are used primarily for diagnosis:

(a). Medial Branch Blocks. Medial Branch Blocks are primarily diagnostic injections, used to determine whether a patient is a candidate for radiofrequency medial branch neurotomy (also known as facet rhizotomy). ISIS suggests controlled blocks – using either placebo or anesthetics with varying lengths of activity (i.e., bupivacaine longer than lidocaine). To be a positive diagnostic block, the patient should report a reduction of pain of 50 percent or greater relief from baseline for the length of time appropriate for the local anesthetic used. In almost all cases, this will mean a reduction of pain to 1 or 2 on the visual analog scale (VAS) 10-point scale correlated with functional improvement. The patient should also identify activities of daily living (which may include measurements of range of motion) that are impeded by their pain and can be observed to document functional improvement in the clinical setting. Ideally, these activities should be assessed throughout the observation period for function. The observer should not be the physician who performed the procedure. It is suggested that this be recorded on a form similar to ISIS recommendations. A separate comparative block on a different date should be performed to confirm the level of involvement. A comparative block uses anesthetics of varying lengths of activity. Medial Branch blocks are probably not helpful to determine the likelihood of success for spinal fusion.

(i). Frequency and Maximum Duration: May be repeated once for comparative blocks. Limited to four levels.

(b). Transforaminal Injections/ Selective Nerve Root Blocks are useful in identifying spinal pathology. When performed for diagnosis, small amounts of local anesthetic up to a total volume of 1.0 cc should be used to determine the level of nerve root irritation. A positive diagnostic block should result in a positive diagnostic functional benefit and an 50 percent reduction in nerve-root generated pain appropriate for the anesthetic used as measured by accepted pain scales (such as a VAS).

(i). Time to produce effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients.

(ii). Frequency and Maximum Duration: Once per suspected level. Limited to two levels.

(c). Zygapophyseal (facet) blocks: Facet blocks are generally accepted but should not be considered diagnostic blocks for the purposes of determining the need for a rhizotomy (radiofrequency medial branch neurotomy), nor should they be done with medial branch blocks. These blocks should not be considered a definitive diagnostic tool. They may be used diagnostically to direct functional rehabilitation programs. A positive diagnostic block should result in a positive diagnostic functional benefit and an 50%

reduction in pain appropriate for the anesthetic used as measured by accepted pain scales (such as a Visual Analog Scale). They then may be repeated per the therapeutic guidelines when they are accompanied by a functional rehabilitation program. (Refer to section F. 5. a. Therapeutic Spinal Injections).

(i). Time to produce effect: Less than 30 minutes for local anesthesia; corticosteroids up to 72 hours for most patients

(ii). Frequency and Maximum Duration: Once per suspected level, limited to two levels

(d). Atlanto-Axial and Atlanto-Occipital Injections: are generally accepted for diagnosis and treatment but do not lend themselves to denervation techniques owing to variable neuroanatomy. Injection of this articulation is complicated by the proximity of the vertebral artery, which may be tortuous at the level of the C1 joint. Inadvertent injection of the vertebral artery may cause respiratory arrest, seizure, stroke, or permanent neurological sequelae. Only practitioners skilled in these injections should perform them.

(i). Frequency and Maximum Duration: Once per side

(e). Sacroiliac Joint Injection

(i). Description—a generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under fluoroscopic guidance. Long-term therapeutic effect has not yet been established.

(ii). Indications — Primarily diagnostic to rule out sacroiliac joint dysfunction versus other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick’s test) and at least 50 percent pain relief on post-injection physical exam (as measured by accepted pain scales such as VAS) correlated with functional improvement. Sacroiliac joint blocks should facilitate functionally directed rehabilitation programs.

(iii). Time to produce effect: Up to 30 minutes for local anesthetic

(iv). Frequency and Maximum Duration: 1

b. Other Diagnostic Injections: These injections are frequently employed in assessing the type of pain a patient may be having. They also aid in ascertaining possible mechanisms and origins of the pain as well as the site of the pain source. Some diagnostic injections have therapeutic properties that may be used to both diagnose and treat chronic pain. In those cases, refer to Non-Operative Treatment – Therapeutic Injections for specific information regarding these injections.

i. Description—generally accepted, well-established procedures. These injections may be useful for localizing the source of pain, and may have added therapeutic value when combined with injection of therapeutic medication(s). Each diagnostic injection has inherent risks, and risk versus benefit should always be evaluated when considering injection therapy. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information

indicating strong suspicion for pathologic condition(s) and the source of pain symptoms.

ii. The interpretation of the test result is primarily based upon pain response; the diagnostic significance of the test result should be evaluated in conjunction with clinical information and the results of other diagnostic procedures. Injections with local anesthetics of differing duration are required to confirm a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose pain. Refer to Therapeutic Injections for information on specific injections.

iii. Special Requirements for Diagnostic Injections—Since fluoroscopic, arthrographic and/or CT guidance during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. The subspecialty disciplines of the physicians may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner should have experience in ongoing injection training workshops provided by organizations such as the International Spine Injection Society (ISIS) and be knowledgeable in radiation safety. In addition, practitioners should obtain fluoroscopy training and radiation safety credentialing from their Departments of Radiology, as applicable.

iv. Complications — General complications of diagnostic injections may include transient neurapraxia, nerve injury, infection, headache, vasovagal effects, as well as epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and spinal meningial abscess. Severe complications of cervical injections are remote but can include spinal cord damage, quadriplegia, and/or death.

v. Contraindications—Absolute contraindications of diagnostic injections include: bacterial infection—systemic or localized to region of injection; bleeding diatheses; hematological conditions; and possible pregnancy. Relative contraindications of diagnostic injections may include, allergy to contrast or shellfish, poorly controlled Diabetes Mellitus or hypertension, and aspirin/NSAIDs/antiplatelet therapy (drug may be held for three days or more, depending on the medication, prior to injection).

vi. Specific Diagnostic Injections — In general, relief should last for at least the duration of the local anesthetic used and give significant relief of pain. Refer to Therapeutic Injections for information on other specific therapeutic injections. The following injections are used primarily for diagnosis.

(a). Sympathetic Injections: are diagnostic injections that may be used in suspected cases of CRPS-I. Refer to the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines for specific information regarding the use of these injections.

(b). Peripheral Nerve Blocks: are diagnostic injections that may be used in for specific nerve injury or entrapment syndromes. Refer to Injections – Therapeutic for detailed information about their use.

6. Special tests are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and/or physical work demand classifications and tolerance.

a. Computer-enhanced evaluations: Computer-enhanced evaluations may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range of motion, endurance, or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment and demonstrated motivation. These evaluations should not be used alone to determine return to work restrictions.

i. Frequency: One time for evaluation. Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. Functional Capacity Evaluation (FCE): is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return-to-work. This test may also be known as Physical Capacity Evaluation, Functional Capacity Assessment, and Work Capacity Evaluation. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range of motion, coordination and strength, worker habits, employability and financial status, as well as psychosocial aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; non-material and material handling activities; and (i) validity of effort and reproducibility. Standardized national guidelines (such as National Institute for Occupational Safety and Health (NIOSH)) should be used as the basis for FCE recommendations.

i. Frequency: Can be used initially to determine baseline status. Additional evaluations can be performed to monitor and assess progress and aid in determining the endpoint for treatment.

c. Job Site Evaluation: is a comprehensive analysis of the physical, mental, and sensory components of a specific job. The goal of the Job Site evaluation is to identify any job modification needed to ensure the safety of the employee upon return to work. These components may include, but are not limited to postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; environmental requirements of a job; repetitiveness; and essential functions of a job; and ergonomic set up. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

i. Frequency: One time with additional visits as needed for follow-up per Job Site.

d. Vocational Assessment. The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of Maximum Medical Improvement should not be delayed solely due to lack of attainment of a vocational assessment.

i. Frequency: One time with additional visits as needed for follow-up

e. Work Tolerance Screening: is a determination of an individual's tolerance for performing a specific job based on a job activity or task. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. May be used when a full FCE is not indicated.

i. Frequency: One time for evaluation. May monitor improvements in strength every three to four weeks up to a total of 6 evaluations.

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### §2111. Therapeutic Procedures—Non-Operative

A. Non-operative therapeutic rehabilitation is applied to patients with chronic and complex problems of de-conditioning and functional disability. Treatment modalities may be utilized sequentially or concomitantly depending on chronicity and complexity of the problem, and treatment plans should always be based on a diagnosis utilizing appropriate diagnostic procedures.

B. Before initiation of any therapeutic procedure, the authorized treating physician, employer, and insurer must consider these important issues in the care of the injured worker:

1. Patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to Return-to-Work in this section for detailed information.

2. Reassessment of the patient's status in terms of functional improvement should be documented after each treatment. If patients are not responding within the recommended time periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued. Continued treatment should be monitored using objective measures such as:

- a. return-to-work or maintaining work status;
- b. fewer restrictions at work or performing activities of daily living;
- c. decrease in usage of medications;
- d. measurable functional gains, such as increased range of motion or documented increase in strength;

3. Clinicians should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

4. Psychological or psychosocial screening should be performed on all chronic pain patients.

C. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation and there is some scientific evidence to support its use. Credentialed practitioners must perform acupuncture evaluations, with experience in evaluation and treatment of chronic pain patients. The exact mode of action is only partially understood. Western medicine studies suggest that

acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. It is commonly used when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation, surgical intervention, and/or as part of multidisciplinary treatment to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Acupuncture is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

- i. Time to produce effect: three to six treatments
- ii. Frequency: one to three times per week
- iii. Optimum duration: one to two months
- iv. Maximum duration: 14 treatments

b. Acupuncture with Electrical Stimulation: is the use of electrical current (micro- amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

- i. Time to produce effect: three to six treatments
- ii. Frequency: 1 to 3 times per week
- iii. Optimum duration: 1 to 2 months
- iv. Maximum duration: 14 treatments

c. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities.

- i. Time to produce effect: three to six treatments
- ii. Frequency: one to three times per week
- iii. Optimum duration: one to two months
- iv. Maximum duration: 14 treatments

(a). Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

2. Biofeedback is a generally well-accepted form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Stress-related psychophysiological reactions may arise as a reaction to organic pain and in some cases may cause pain. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely with coaching by a biofeedback specialist.

a. Indications for biofeedback include individuals who are suffering from musculoskeletal injury where muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of pain, anxiety, panic, anger or emotional distress, narcotic withdrawal, insomnia/ sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized for relaxation training. Mental health professionals may also utilize it as a component of psychotherapy, where biofeedback and other behavioral techniques are integrated with psychotherapeutic interventions. Biofeedback is often used in conjunction with physical therapy or medical treatment.

b. Recognized types of biofeedback include the following:

i. Electromyogram (EMG): Used for self-management of pain and stress reactions involving muscle tension.

ii. Skin Temperature: Used for self-management of pain and stress reactions, especially vascular headaches.

iii. Respiration Feedback (RFB): Used for self-management of pain and stress reactions via breathing control.

iv. Respiratory Sinus Arrhythmia (RSA): Used for self-management of pain and stress reactions via synchronous control of heart rate and respiration. Respiratory sinus arrhythmia is a benign phenomena which consists of a small rise in heart rate during inhalation, and a corresponding decrease during exhalation. This phenomenon has been observed in meditators and athletes, and is thought to be a psychophysiological indicator of health.

v. Heart Rate Variability (HRV): Used for self-management of stress via managing cardiac reactivity.

vi. Electrodermal Response (EDR): Used for self-management of stress involving palmar sweating or galvanic skin response.

vii. Electroencephalograph (EEG, QEEG): Used for self-management of various psychological states by controlling brainwaves.

c. The goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques. In the course of biofeedback treatment, patient stressors are discussed and self-management strategies are devised. If the patient has not been previously evaluated, a psychological evaluation should be performed prior to beginning biofeedback treatment for chronic pain. The psychological evaluation may reveal cognitive difficulties, belief system conflicts,

somatic delusions, secondary gain issues, hypochondriasis, and possible biases in patient self-reports, which can affect biofeedback. Home practice of skills is often helpful for mastery and may be facilitated by the use of home training tapes.

d. Psychologists or psychiatrists, who provide psychophysiological therapy which integrates biofeedback with psychotherapy, should be either Biofeedback Certification Institute of America (BCIA) certified or practicing within the scope of their training. All other providers of Biofeedback for chronic pain patients must be BCIA certified and shall have their biofeedback treatment plan approved by the authorized treating psychologist or psychiatrist. Biofeedback treatment must be done in conjunction with the patient's psychosocial intervention. Biofeedback may also be provided by unlicensed health care providers, who follow a set treatment and educational protocol. Such treatment may utilize standardized material or relaxation tapes.

i. Time to produce effect: three to four sessions

ii. Frequency: one to two times per week

iii. Optimum duration: six to eight sessions

iv. Maximum duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic or functional gains.

3. Disturbances of sleep are common in chronic pain. Although primary insomnia may accompany pain as an independent co-morbid condition, it more commonly occurs secondary to the pain condition itself. Exacerbations of pain often are accompanied by exacerbations of insomnia; the reverse can also occur. Sleep laboratory studies have shown disturbances of sleep architecture in pain patients. Loss of deep slow-wave sleep and increase in light sleep occur and sleep efficiency, the proportion of time in bed spent asleep, is decreased. These changes are associated with patient reports of non-restorative sleep.

a. Many chronic pain patients develop behavioral habits that exacerbate and maintain sleep disturbances. Excessive time in bed, irregular sleep routine, napping, low activity, and worrying in bed are all maladaptive responses that can arise in the absence of any psychopathology. There is some evidence that behavioral modification, such as patient education and group or individual counseling, can be effective in reversing the effects of insomnia. Behavioral modifications are easily implemented and can include:

i. maintaining a regular sleep schedule, retiring and rising at approximately the same time on weekdays and weekends;

ii. avoiding daytime napping;

iii. avoiding caffeinated beverages after lunchtime;

iv. making the bedroom quiet and comfortable, eliminating disruptive lights, sounds, television sets, and keeping a bedroom temperature of about 65°F;

v. avoiding alcohol or nicotine within two hours of bedtime;

vi. avoiding large meals within two hours of bedtime;

vii. exercising vigorously during the day, but not within two hours of bedtime, since this may raise core temperature and activate the nervous system;

viii associating the bed with sleep and sexual activity only, using other parts of the home for television, reading and talking on the telephone;

ix. leaving the bedroom when unable to sleep for more than 20 minutes, returning to the bedroom when ready to sleep again.

b. These modifications should be undertaken before sleeping medication is prescribed for long term use.

#### 4. Injections - Therapeutic

a. When considering the use of injections in chronic pain management, the treating physician must carefully consider the inherent risks and benefits. First, it is understood that these injections are seldom meant to be "curative" and when used for therapeutic purposes they are employed in conjunction with other treatment modalities for maximum benefit.

b. Second, education of the patient should include the proposed goals of the injections, expected gains, risks or complications, and alternative treatment.

c. Lastly, reassessment of the patient's status in terms of functional improvement should be documented after each injection and/or series of injections. Any continued use of injections should be monitored using objective measures such as:

i. return-to-work or maintaining work status;

ii. fewer restrictions at work or performing activities of daily living;

iii. decrease in usage of medications;

iv. measurable functional gains, such as increased range of motion for documented increase in strength.

d. Visual analog scales (VAS) provide important subjective data but cannot be used to measure function.

e. The physician must be aware of the possible placebo effect as well as the long-term effects of injections related to the patient's physical and mental status. Strict adherence to contraindications, both absolute and relative, may prevent potential complications. Subjecting the patient to potential risks, i.e., needle trauma, infection, nerve injury, or systemic effects of local anesthetics and corticosteroids, must be considered before the patient consents to such procedures.

##### i. Spinal Therapeutic Injections

(a). General Description –The following injections are considered to be reasonable treatment for patients with chronic pain. Other injections not listed may be beneficial. Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, etc., have been undertaken. Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology. Injections are invasive procedures that can cause serious complications; thus clinical indications and contraindications should be closely adhered to. The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. All patients should continue appropriate exercise with functionally directed rehabilitation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered (Refer to Active Therapy). Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with

modified work achieves long-term relief by increasing active ROM, strength, and stability. If the first injection does not provide a diagnostic response with temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50% pain reduction), and improvement in function, similar injections should not be repeated. Cervical injections are invasive procedures that can cause catastrophic complications. Refer to the Cervical Spine Injury guideline for more specific contraindications.

(b). Special Considerations – For all spinal injections (excluding trigger point, botox and occipital or peripheral nerve blocks) multi-planar fluoroscopy, during procedures is required to document technique and needle placement, and should be performed by a physician experienced in the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the physicians may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner who performs injections for low back pain should document hands on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. The practitioner who performs injections for cervical pain should have completed fellowship training in pain medicine with interventional training, or its equivalent. Practitioners who perform spinal injections must also be knowledgeable of radiation safety.

(c). Complications – General complications of these spinal injections may include transient neurapraxia, local pain, nerve injury, infection, headache, urinary retention and vasovagal effects; epidural hematoma, permanent neurologic damage, dural perforation and cerebral spinal fluid (CSF) leakage, and/or spinal meningeal abscess may also occur; Permanent paresis, anaphylaxis and arachnoiditis have been rarely reported with the use of epidural steroids. With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary adrenal axis lasting between one and three months. For cervical injections, severe complications are remote but can include spinal cord damage, quadriplegia, and/or death.

(d). Contraindications – Absolute contraindications of therapeutic injections include: bacterial infection – systemic or localized to region of injection; bleeding diatheses; hematological conditions, and (d) possible pregnancy. Relative contraindications may include allergy to contrast or shellfish; poorly controlled Diabetes Mellitus or hypertension. Drugs affecting coagulation may require restriction from use. Anti-platelet therapy and anti-coagulations should be addressed individually by a knowledgeable specialist. It is recommended to refer to the American Society of Regional Anesthesia for anticoagulation guidelines.

##### (e). Epidural Steroid Spinal Injections

(i). Description – Epidural steroid injections (ESI) deliver corticosteroid into the epidural space. The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs. ESI uses three approaches: transforaminal, translaminar (midline), and caudal.

(ii). For ESI in the low back, the transforaminal approach is the preferred method for unilateral, single-level pathology and for post-surgical patients. Also for the low back, there is good evidence that the transforaminal approach can deliver medication to the target tissue with few complications and can be used to identify the specific site of pathology. The interlaminar approach is the preferred approach for multi-level pathology or spinal stenosis in the lumbar spine. Caudal therapeutic injections may be used, but it is difficult to target the exact treatment area, due to diffuse distribution.

(iii). Needle Placement – Multi-planar fluoroscopic imaging is required for all transforaminal epidural steroid injections. Contrast epidurograms allow one to verify the flow of medication into the epidural space. Permanent images are required to verify needle placement.

(iv). Indications – There is some evidence that epidural steroid injections are effective for patients with radicular pain or radiculopathy (sensory or motor loss in a specific dermatome or myotome). Although there is no evidence regarding the effectiveness of ESI for non-radicular pain, it is a generally accepted intervention. Only patients who have pain affected by activity and annular tears verified by appropriate imaging may have injections for axial pain.

(v). There is some evidence that ESI injections in the low back are not effective for spinal stenosis without radicular findings. Additionally, there is some evidence in studies of the lumbar spine that patients who smoke or who have pain unaffected by rest or activity are less likely to have a successful outcome from ESIs.

[a]. Time to produce effect: Local anesthetic, less than 30 minutes; corticosteroid, 48 to 72 hours for 80 percent of patients and 72 hours to 2 weeks for 20 percent of patients.

[i]. Frequency: One or more divided levels can be injected in one session. Whether injections are repeated depends upon the patient's response to the previous injection. Subsequent injections may occur after 1 to 2 weeks if there is a positive patient response. Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain response (via a recognized pain scale) and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

[b]. Injections can be repeated after a hiatus of six months if the patient has demonstrated functional gain and pain returns or worsens. If the first injection does not provide a diagnostic response of temporary and sustained pain relief (at least two to six weeks) substantiated by accepted pain scales (i.e., 50 percent pain reduction as measured by tools such as VAS) and improvement in function, similar injections should not be repeated.

[c]. Optimum: Usually one up to three injection(s) over a period of six months, depending upon each patient's response and functional gain.

[d]. Maximum: Two sessions (consisting of up to three injections each) may be done in one year based upon the patient's response to pain and function. Patients should be reassessed after each injection session for a 50 percent improvement in pain (as measured by accepted pain scales) and evidence of functional improvement.

(f). Zygapophyseal (Facet) Injection

(i). Description – A generally accepted intra-articular or pericapsular injection of local anesthetic and corticosteroid. Medial branch nerve blocks may be diagnostic only. There is conflicting evidence to support a long-term therapeutic effect using facet injections. There is no justification for a combined facet and medial branch block.

(ii). Indications – Patients with pain, suspected to be facet in origin based on exam findings; and affecting activity; or patients who have refused a rhizotomy; or patients who have facet findings with a thoracic component. In these patients, facet injections may be occasionally useful in facilitating a functionally-directed rehabilitation program and to aid in identifying pain generators. Patients with recurrent pain should be evaluated with more definitive diagnostic injections, such as medial nerve branch injections, to determine the need for a rhizotomy. Because facet injections are not likely to produce long-term benefit by themselves and are not the most accurate diagnostic tool, they should not be performed at more than two levels.

(iii). Facet injections may be repeated if they result in increased documented functional benefit for at least four to six weeks and at least an 50 percent initial improvement in pain as measured by accepted pain scales (such as VAS).

[a]. Time to produce effect: Up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

[b]. Frequency: one injection per level with a diagnostic response. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least four to six weeks of functional benefit should be obtained with each therapeutic injection.

[c]. Optimum duration: two to three injections for each applicable joint per year. Not to exceed two joint levels.

[d]. Maximum Duration: four per level per year. Prior authorization must be obtained for injections beyond two levels.

(g). Sacroiliac Joint Injection

(i). Description – A generally accepted injection of local anesthetic in an intra-articular fashion into the sacroiliac joint under radiographic guidance. May include the use of corticosteroids. Long-term therapeutic effect has not yet been established.

(ii). Indications – Primarily diagnostic to rule out sacroiliac joint dysfunction vs. other pain generators. Intra-articular injection can be of value in diagnosing the pain generator. There should be documented relief from previously painful maneuvers (e.g., Patrick's test) on post-injection physical exam. These injections may be repeated if they result in increased documented functional

benefit for at least 6 weeks and at least an 50 percent initial improvement in pain scales as measured by accepted pain scales (such as VAS). Sacroiliac joint blocks should facilitate a functionally directed rehabilitation program.

[a]. Time to produce effect: Approximately 30 minutes for local anesthetic; 48 to 72 hours for corticosteroid.

[b]. Frequency and Optimum Duration: two injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e., 80 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection.

[c]. Maximum Duration: three injections per year.

## ii. Trigger Point Injections

(a). Description – Trigger point injection consists of dry needling or injection of local anesthetic with or without corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response.

(b). Indications – Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other active treatment modalities. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue in an aggressive aerobic and stretching therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Trigger point injections are indicated in those patients where well-circumscribed trigger points have been consistently observed, demonstrating a local twitch response characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a four-week timeframe.

(c). Complications – Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, penetration of viscera, neurapraxia and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local myopathy developing. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

(i). Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia.

(ii). Frequency: Weekly. Suggest no more than four injection sites per session per week to avoid significant post-injection soreness.

(iii). Optimum duration: four sessions.

(iv). Maximum duration: eight weeks. Some patients may require two to four repetitions of trigger point injection series over a one to two year period.

(v). Botulinum Toxin (Botox) Injection:

[a]. Description – Used to temporarily weaken or paralyze muscles. May reduce muscle pain in conditions associated with spasticity, dystonia, or other types of painful muscle spasm. Neutralizing antibodies develop in at least four percent of patients treated with botulinum toxin type A, rendering it ineffective. Several antigenic types of botulinum toxin have been described. Botulinum toxin type B, first approved by the Food and Drug Administration (FDA) in 2001, is similar pharmacologically to botulinum toxin type A, and there is good evidence of its efficacy in improving function in cervical dystonia (torticollis). It appears to be effective in patients who have become resistant to the type A toxin. The immune responses to botulinum toxins type A and B are not cross-reactive, allowing type B toxin to be used when type A action is blocked by antibody. Experimental work with healthy human volunteers suggests that muscle paralysis from type B toxin is not as complete or as long lasting as that resulting from type A. The duration of treatment effect of botulinum toxin type B for cervical dystonia has been estimated to be 12 to 16 weeks. EMG needle guidance may permit more precise delivery of botulinum toxin to the target area.

[b]. Indications – To improve range of motion and reduce painful muscle spasm. May be useful in musculoskeletal conditions associated with muscle spasm or headaches. There should be evidence of limited range of motion prior to the injection. May be useful in central neurologic conditions that produce spasticity or dystonia (e.g., brain injury, spinal cord injury, or stroke).

[c]. Complications – Over-weakening of injected muscles, allergic reaction to medications. Rare systemic effects include flu-like syndrome, weakening of distant muscle. There is an increased risk of systemic effects in patients with motor neuropathy or disorders of the neuromuscular junction.

[i]. Time to produce effect: 24 to 72 hours post injection with peak effect by four to six weeks.

[ii]. Frequency: No less than three months between re-administration.

[iii]. Optimum duration: three to four months.

[iv]. Maximum duration: Currently unknown. Repeat injections should be based upon functional improvement and therefore used sparingly in order to avoid development of antibodies that might render future injections ineffective.

5. Interdisciplinary rehabilitation programs: are the gold standard of treatment for individuals with chronic pain who have not responded to less intensive modes of treatment. In addition, there are current studies to support the use of pain programs. There is strong evidence that interdisciplinary programs improve function in chronic pain

and moderate evidence that these programs decrease pain in these patients.

a. These programs should assess the impact of pain and suffering on the patient's medical, physical, psychological, social, and/or vocational functioning. In general, interdisciplinary programs deal with irreversible, painful musculoskeletal, neurological, and other chronic painful disorders and psychological issues, including drug dependence, high levels of stress and anxiety, failed surgery and pre-existing or latent psychopathology. The number of professions involved in the team in a chronic pain program may vary due to the complexity of the needs of the person served. The OWCA recommends consideration of referral to an interdisciplinary program within 6 months post-injury in patients with delayed recovery unless surgical interventions or other medical complications intervene.

b. Chronic pain patients need to be treated within a continuum of treatment intensity. Chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated by the authorized treating physician (informal). Formal programs are able to provide coordinated, high intensity level of services and are recommended for most chronic pain patients who have received multiple therapies during acute management. Informal programs offer a lesser intensity of service and may be considered for patients who are currently employed, those who cannot attend all day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach, methods, and goals. Generally the type of program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social and/or vocational functioning.

c. When referring a patient for formal interdisciplinary pain rehabilitation or Work Hardening programs, the OWCA recommends the programs be Commission on Accreditation of Rehabilitation Facilities (CARF) eligible and/or certified. CARF eligibility or certification ensures that programs meet specific care standards of design and efficacy.

d. Inpatient Pain Rehabilitation Programs are rarely needed but may be necessary for patients with any of the following conditions: High risk for medical instability; Moderate to severe impairment of physical/functional status; Moderate to severe pain behaviors; Moderate impairment of cognitive and/or emotional status; Dependence on medications from which he or she needs to be withdrawn; and The need for 24-hour supervised nursing.

e. Interdisciplinary pain programs, whether formal or informal, should be comprised of the following dimensions.

i. Communication. To ensure positive functional outcomes, communication between the patient, insurer and all professionals involved must be coordinated and consistent. Any exchange of information must be provided to all professionals, including the patient. Care decisions would be communicated to all.

ii. Documentation. Through documentation by all professionals involved and/or discussions with the patient, it should be clear that functional goals are being actively

pursued and measured on a regular basis to determine their achievement or need for modification.

iii. Treatment Modalities. Use of modalities may be necessary early in the process to facilitate compliance with and tolerance to therapeutic exercise, physical conditioning, and increasing functional activities. Active treatments should be emphasized over passive treatments. Active treatments should encourage self-coping skills and management of pain, which can be continued independently at home or at work. Treatments that can foster a sense of dependency by the patient on the caregiver should be avoided. Treatment length should be decided based upon observed functional improvement. For a complete list of Active and Passive Therapies, refer to those subparagraphs in this guideline. All treatment timeframes may be extended based upon the patient's positive functional improvement.

iv. Therapeutic Exercise Programs. There is strong evidence that these programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize education, independence, and the importance of an on-going exercise regime.

v. Return-to-work: The authorized treating physician should continually evaluate the patient for their potential to return to work. When return-to-work is an option, it may be appropriate to implement a Work Hardening Program (as described in this section). For patients currently employed, efforts should be aimed at keeping them employed. For more specific information regarding return-to-work, refer to the Return-to-work section in this guideline.

vi. Patient Education: Patients with pain need to re-establish a healthy balance in lifestyle. All providers should educate patients on how to overcome barriers to resuming daily activity, including pain management, decreased energy levels, financial constraints, decreased physical ability, and change in family dynamics.

vii. Psychosocial Evaluation and Treatment: Psychosocial evaluation should be initiated, if not previously done. Providers of care should have a thorough understanding of the patient's personality profile; especially if dependency issues are involved. Psychosocial treatment may enhance the patient's ability to participate in pain treatment rehabilitation, manage stress, and increase their problem-solving and self-management skills.

viii. Vocational Assistance: Vocational assistance can define future employment opportunities or assist patients in obtaining future employment. Refer to Return-to-work section for detailed information.

f. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of the treatment program. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. The following programs are listed in order of decreasing intensity.

i. Formal Rehabilitation Programs:

(a). Interdisciplinary Pain Rehabilitation: An Interdisciplinary Pain Rehabilitation Program provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services to measure and improve the functioning of persons with pain and encourage their appropriate use of health care system and services. The program can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. The program shares information about the scope of the services and the outcomes achieved with patients, authorized providers, and insurers.

(b). The interdisciplinary team maintains consistent integration and communication to ensure that all interdisciplinary team members are aware of the plan of care for the patient, are exchanging information, and implement the plan of care. The team members make interdisciplinary team decisions with the patient and then ensure that decisions are communicated to the entire care team.

(c). The medical director of the pain program should be board certified in his or her specialty area, have at least two years full-time experience in an interdisciplinary pain rehabilitation program, and ideally be board certified in pain management. Individuals who assist in the accomplishment of functional, physical, psychological, social and vocational goal must include, at the least, a medical director, pain physician(s), psychologist, Biofeedback Therapist, Occupational Therapist, Physical Therapist, and Registered Nurse. Other disciplines on the team may include, but are not limited to, case manager, exercise physiologist, psychiatrist, and/or nutritionist.

(i). Time to produce effect: three to four weeks

(ii). Frequency: No less than five hours/day, five days/week

(iii). Optimum duration: three to four weeks five times a week, followed by six to nine weeks of follow-up one to three times a week.

(iv). Maximum duration: four months, including follow-up. Periodic review and monitoring thereafter on an as needed basis, is founded upon the documented maintenance of functional gains.

(d). Work Hardening is an interdisciplinary program addressing a patient's employability and return-to-work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. A full workday is case specific and is defined by the previous employment of the patient. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

(e). The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation, team physicians having experience in occupational rehabilitation, occupational therapy, physical therapy, case manager, and psychologist. As appropriate, the team may also include: chiropractor, RN, or vocational specialist.

(i). Time to produce effect: two weeks

(ii). Frequency: two to five visits per week, up to eight hours/day.

(iii). Optimum duration: two to four weeks

(iv). Maximum duration: six weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Informal Rehabilitation Program: A Coordinated Interdisciplinary Pain Rehabilitation Program is one in which the authorized treating physician coordinates all aspects of care. This type of program is similar to the formal programs in that it is goal oriented and provides interdisciplinary rehabilitation services to manage the needs of the patient in the following areas, functional; medical; physical; psychological; social; and vocational.

(a). This program is different from a formal program in that it involves lesser frequency and intensity of services/treatment. Informal rehabilitation is geared toward those patients who do not need the intensity of service offered in a formal program or who cannot attend an all-day program due to employment, daycare, language or other barriers.

(b). Patients should be referred to professionals experienced in outpatient treatment of chronic pain. The OWCA recommends the authorized treating physician consult with physicians experienced in the treatment of chronic pain to develop the plan of care.

(i). Time to produce effect: three to eight weeks

(ii). Frequency: two to six hours per day, two to five days each week.

(iii). Optimum duration: 6 to 12 weeks, including follow-up.

(iv). Maximum duration: four months, including follow-up. Periodic review and monitoring thereafter on an as needed basis, is founded upon the documented maintenance of functional gains.

6. Medications. There is no single formula for pharmacological treatment of patients with chronic nonmalignant pain. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Appropriate application of pharmacological agents depends on the patient's age, past history (including history of substance abuse), drug allergies and the nature of all medical problems. It is incumbent upon the physician to thoroughly understand pharmacological principles when dealing with the different drug families and their respective side effects, bioavailability profiles, and primary reason for each medication's usage.

a. Control of chronic non-malignant pain is expected to involve the use of medication. Strategies for pharmacological control of pain cannot be precisely specified in advance. Rather, drug treatment requires close monitoring of the patient's response to therapy, flexibility on the part of the prescriber and a willingness to change treatment when circumstances change. Many of the drugs discussed in the medication section were licensed for indications other than analgesia, but are effective in the control of many types of chronic pain. Consensus regarding the use of opioids has generally been reached in the field of cancer pain, where nociceptive mechanisms are generally identifiable, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In injured workers, by contrast, central and

neuropathic mechanisms frequently overshadow nociceptive processes, expected survival is relatively long, and return to a high level of function is a major goal of treatment. Approaches to pain, which were developed in the context of malignant pain, therefore may not be transferable to chronic non-malignant pain.

b. All medications should be given an appropriate trial in order to test for therapeutic effect. Trials of medication requiring specific therapeutic drug levels may take several months to achieve, depending upon the half-life of the drug. It is recommended that patients with chronic nonmalignant pain be maintained on drugs that have the least serious side effects. For example, patients need to be tried or continued on acetaminophen and/or antidepressant medications whenever feasible as part of their overall treatment for chronic pain. It is recommended that use of opioid analgesic and sedative hypnotic medications in chronic pain patients be used in a very limited manner, with total elimination desirable whenever clinically feasible.

c. The preceding principles do not apply to chronic headache patients. These patients should be referred to a physician specializing in the diagnosis and treatment of headache and facial pain.

d. For the clinician to interpret the following material, it should be noted that drug profiles listed are not complete; dosing of drugs will depend upon the specific drug, especially for off-label use; and not all drugs within each class are listed, and other drugs within the class may be appropriate. Clinicians should refer to informational texts or consult a pharmacist before prescribing unfamiliar medications or when there is a concern for drug interactions.

e. The following drug classes are listed in alphabetical order, not in order of suggested use.

i. Alpha-Acting Agents: Noradrenergic pain-modulating systems are present in the central nervous system, and the Alpha-2 adrenergic receptor may be involved in the functioning of these pathways. Alpha-2 agonists may act by stimulating receptors in the substantia gelatinosa of the dorsal horn of the spinal cord, inhibiting the transmission of nociceptive signals. Spasticity may be reduced by presynaptic inhibition of motor neurons. Given limited experience with their use, they cannot be considered first-line analgesics, but a trial of their use may be warranted in many cases of refractory pain.

(a). Clonidine (Catapres)

(i). Description – Central Alpha 2 agonist.  
(ii). Indications – Sympathetically mediated pain, treatment of withdrawal from opioids.

(iii). Major Contraindications – Severe coronary insufficiency, renal impairment.

(iv). Dosing and Time to Therapeutic Effect – Increase dosage weekly to therapeutic effect.

(v). Major Side Effects – Sedation, orthostatic hypotension, sexual dysfunction, thrombocytopenia, weight gain, agitation, rebound hypertension with cessation.

(vi). Drug Interactions – Beta adrenergics, tricyclic antidepressants.

(vii). Recommended Laboratory Monitoring – Renal function.

(b). Tizanidine (Zanaflex)

(i). Description – Alpha 2 adrenergic agonist.

(ii). Indications – Spasticity, musculoskeletal disorders.

(iii). Major Contraindications – Hepatic disease.

(iv). Dosing and Time to Therapeutic Effect – As needed (PRN) or titrate to effective dose.

(v). Major Side Effects – Hypotension, sedation, hepatotoxicity, hallucinations and psychosis, dry mouth.

(vi). Drug Interactions – Alcohol, oral contraceptives, and acetaminophen. Use with caution with other alpha agonists.

(vii). Recommended Laboratory Monitoring – Hepatic and renal function.

ii. Anticonvulsants: Although the mechanism of action of anticonvulsant drugs in neuropathic pain states remains to be fully defined, they appear to act as nonselective sodium channel blocking agents. A large variety of sodium channels are present in nervous tissue, and some of these are important mediators of nociception, as they are found primarily in unmyelinated fibers and their density increases following nerve injury. While the pharmacodynamic effects of the various anticonvulsant drugs are similar, the pharmacokinetic effects differ significantly. Carbamazepine has important effects as an inducer of hepatic enzymes and may influence the metabolism of other drugs enough to present problems in patients taking more than one drug. Gabapentin and oxcarbazepine, by contrast, are relatively non-significant enzyme inducers, creating fewer drug interactions. Because anticonvulsant drugs may have more problematic side-effect profiles, their use should usually be deferred until antidepressant drugs have failed to relieve pain.

(a). Gabapentin (Neurontin)

(i). Description – Structurally related to gamma-aminobutyric acid (GABA) but does not interact with GABA receptors.

(ii). Indications – Neuropathic pain.

(iii). Relative Contraindications – Renal insufficiency.

(iv). Dosing and Time to Therapeutic Effect – Dosage may be increased over several days.

(v). Major Side Effects – Confusion, sedation.

(vi). Drug Interactions – Oral contraceptives, cimetidine, antacids.

(vii). Recommended Laboratory Monitoring – Renal function.

(b). Oxcarbazepine (Trileptal)

(i). Description – The mechanism of action resembles that of carbamazepine, but has an advantage in being a less potent inducer of hepatic enzymes. Controlled trials of its effectiveness in chronic pain are lacking.

(ii). Indications – Neuropathic pain.

(iii). Major Contraindications – Hypersensitivity to carbamazepine.

(iv). Dosing and Time to Therapeutic Effect – Dosage may be increased weekly.

(v). Major Side Effects – Sedation, visual disturbances.

(vi). Drug Interactions – Oral contraceptives, valproic acid, carbamazepine.

(vii). Recommended Laboratory Monitoring – Drug levels, renal and hepatic function.

(c). Carbamazepine (Tegretol)

(i). Description – Anticonvulsant structurally related to tricyclic antidepressants.

(ii). Indications – Trigeminal neuralgia and other neuropathic pain.

(iii). Major Contraindications – Bone marrow depression, hypersensitivity to tricyclic antidepressants.

(iv). Dosing and Time to Therapeutic Effect – Dosage levels typically exceed those utilized for seizure prophylaxis. Titrate to desired effect.

(v). Major Side Effects – Aplastic anemia, agranulocytosis, nausea, diplopia, pulmonary sensitivity, inappropriate antidiuretic hormone, dysphoria, disequilibrium.

(vi). Drug Interactions – Many interactions have been reported including, but not limited to, macrolide antibiotics, valproic acid, SSRI's, propoxyphene, doxycycline, bupropion, anticoagulants, and acetaminophen.

(vii). Recommended Laboratory Monitoring – Drug levels, renal and hepatic function, complete blood count.

iii. Antidepressants: are classified into a number of categories based on their chemical structure and their effects on neurotransmitter systems. Their effects on depression are attributed to their actions on disposition of norepinephrine and serotonin at the level of the synapse; although these synaptic actions are immediate, the symptomatic response in depression is delayed by several weeks. When used for chronic pain, the effects may in part arise from treatment of underlying depression, but may also involve additional neuromodulatory effects on endogenous opioid systems, raising pain thresholds at the level of the spinal cord.

(a). Pain responses may occur at lower drug doses with shorter times to symptomatic response than are observed when the same compounds are used in the treatment of mood disorders. Neuropathic pain, diabetic neuropathy, post-herpetic neuralgia, and cancer-related pain may respond to antidepressant doses low enough to avoid adverse effects that often complicate the treatment of depression.

(i). Tricyclics (e.g., amitriptyline [Elavil], nortriptyline [Pamelor, Aventyl], doxepin [Sinequan, Adapin])

[a]. Description – Serotonergics, typically tricyclic antidepressants (TCAs), are utilized for their serotonergic properties as increasing CNS serotonergic tone can help decrease pain perception in non-antidepressant dosages. Amitriptyline is known for its ability to repair Stage 4 sleep architecture, a frequent problem found in chronic pain patients and to treat depression, frequently associated with chronic pain.

[b]. Indications – Chronic musculoskeletal and/or neuropathic pain, insomnia. Second line drug treatment for depression.

[c]. Major Contraindications – Cardiac disease or dysrhythmia, glaucoma, prostatic hypertrophy, seizures, suicide risk.

[d]. Dosing and Time to Therapeutic Effect – Varies by specific tricyclic. Low dosages are commonly used for chronic pain and/or insomnia.

[e]. Major Side Effects – Anticholinergic side effects including, but not limited to, dry mouth, sedation, orthostatic hypotension, cardiac arrhythmia, weight gain.

[f]. Drug Interactions – Tramadol (may cause seizures), Clonidine, cimetidine, sympathomimetics, valproic acid, warfarin, carbamazepine, bupropion, anticholinergics, quinolones.

[g]. Recommended Laboratory Monitoring – Renal and hepatic function. EKG for those on high dosages or with cardiac risk.

iv. Serotonin and norepinephrine reuptakes

(a). Description – SSRIs are characterized by the predominance of inhibition of serotonin reuptake at the presynaptic nerve terminal.

(b). Indications – Depression, chronic pain with depression and/or anxiety. Less effective than tricyclic antidepressants for neuropathic pain.

(c). Major Contraindications – Allergy to SSRIs.

(d). Time to Produce Therapeutic Effect – three to four weeks.

(e). Major Side Effects – Insomnia, gastrointestinal (GI) distress, sexual dysfunction.

(f). Drug Interactions – Multiple drug interactions have been reported, including non-sedating antihistamine. May be used in combination with TCAs but therapeutic TCA levels (as used for depression) are known to increase when used in combination with SSRIs and may persist for at least five weeks after discontinuance. Tramadol should not be used with SSRIs due to potential for seizures.

(g). Recommended Laboratory Monitoring – Renal and hepatic function.

v. Atypical Antidepressants/Other Agents

(a). Description – Venlafaxine, (Effexor), nefazadone (Serzone), trazodone (Deseryl), and mirtazapine (Remeron) share adjuvant analgesic effects with tricyclic antidepressants. They differ in their side effect and drug interaction profiles.

(b). Indications – Venlafaxine is approved for generalized anxiety disorder, bupropion for smoking cessation.

(c). Major Contraindications – Seizures, eating disorders.

(d). Major Side Effects – Depends on the drug, but commonly include GI distress, drowsiness, sexual dysfunction less than other classes except trazodone, which may cause priapism. Hypertension (venlafaxine).

(e). Drug Interactions – Drug specific. Prolongation of cardiac output (QT) interval with rare arrhythmias associated with nefazadone and non-sedating antihistamines.

(f). Recommended Laboratory Monitoring – Drug specific.

vi. Hypnotics and Sedatives: Sedative and hypnotic drugs decrease activity, induce drowsiness, and moderate agitation. Many drugs produce these effects incidental to their usual intended effects, similar to the side effects of many antihistamines and antidepressants. Due to the habit-forming potential of the benzodiazepines and other

drugs found in this class, they are not routinely recommended but may be useful in some patients with chronic pain.

(a). Most insomnia in chronic pain patients should be managed primarily through behavioral interventions with medications as secondary measures (refer to Section F.4, Disturbances of Sleep).

(i). Zaleplon (Sonata)

[a]. Description – A nonbenzodiazepine hypnotic.

[b]. Indications – Insomnia.

[c]. Dosing and Time to Therapeutic Effect – Time of onset is 30 to 60 minutes. Due to rapid elimination, may be taken as little as four hours before awakening.

[d]. Major Side Effects – Dizziness, dose-related amnesia.

[e]. Drug Interactions – Increases sedative effect of other central nervous system (CNS) depressant drugs. Use low dose if on cimetidine.

[f]. Recommended Laboratory Monitoring—Hepatic function.

(ii). Zolpidem (Ambien)

[a]. Description – A nonbenzodiazepine hypnotic, which does not appear to cause rebound insomnia. It has little respiratory depression and insignificant anxiolytic or muscle relaxant activity.

[b]. Indications – Short-term use for insomnia

[c]. Time to Therapeutic Effect – Onset of action is 30 to 60 minutes

[d]. Major Side Effects – Dizziness, dose-related amnesia.

[e]. Drug Interactions – Increases sedative effect of other CNS depressant drugs.

[f]. Recommended Laboratory Monitoring – Hepatic function.

vii. Skeletal Muscle Relaxants

(a). Skeletal Muscle Relaxants are most useful for acute musculoskeletal injury or exacerbation of injury. Chronic use of benzodiazepines is discouraged due to their habit-forming potential and due to seizure risk following abrupt withdrawal.

(i). Cyclobenzaprine (Flexeril)

[a]. Description – Structurally related to tricyclics.

[b]. Indications – Chronic pain associated with muscle spasm.

[c]. Major Contraindications – Cardiac dysrhythmias.

[d]. Dosing and Time to Therapeutic Effect – Variable, onset of action is one hour.

[e]. Major Side Effects – Sedation, anticholinergic, blurred vision.

[f]. Drug Interactions – Consider interactions similar to tricyclic antidepressants as listed under antidepressant class.

[g]. Recommended Laboratory Monitoring – Hepatic and renal function.

(ii). Carisoprodol (Soma)

[a]. Description – Mode of action may be central; meprobamate is an active metabolite.

[b]. Indications – Chronic pain associated with muscle spasm.

[c]. Major Contraindications – Sensitivity to meprobamate, renal or hepatic disease.

[d]. Major Side Effects – Sedation, withdrawal symptoms, abuse potential.

[e]. Recommended Laboratory Monitoring – Renal and hepatic function.

(iii). Metaxalone (Skelaxin)

[a]. Description – Central acting muscle relaxant.

[b]. Indications – Muscle spasm.

[c]. Major Contraindications – Hepatic disease, pregnancy, and disposition to drug induced hemolytic anemia.

[d]. Dosing and Time to Therapeutic Effect – Onset of action 1 hour.

[e]. Recommended Laboratory Monitoring – Hepatic function.

viii. Opioids

(a). Opioids are the most powerful analgesics. Their use in acute pain and moderate to severe cancer pain is well accepted. Their use in chronic nonmalignant pain, however, is fraught with controversy and lack of scientific research.

(b). Opioids include some of the oldest and most effective drugs used in the control of severe pain. The discovery of opioid receptors and their endogenous peptide ligands has led to an understanding of effects at the binding sites of these naturally occurring substances. Most of their analgesic effects have been attributed to their modification of activity in pain pathways within the central nervous system; however, it has become evident that they also are active in the peripheral nervous system. Activation of receptors on the peripheral terminals of primary afferent nerves can mediate antinociceptive effects, including inhibition of neuronal excitability and release of inflammatory peptides. Some of their undesirable effects on inhibiting gastrointestinal motility are peripherally mediated by receptors in the bowel wall.

(c). The central nervous system actions of these drugs account for much of their analgesic effect and for many of their other actions, such as respiratory depression, drowsiness, mental clouding, reward effects, and habit formation. With respect to the latter, it is crucial to distinguish between three distinct phenomena: tolerance, dependence, and addiction.

(i). Tolerance refers to a state of adaptation in which exposure to a drug over time causes higher doses of that drug to be required in order to produce the same physiologic effect.

(ii). Dependence refers to a set of disturbances in body homeostasis that leads to withdrawal symptoms, which can be produced with abrupt discontinuation, rapid reduction, decreasing blood levels, and/or by administration of an antagonist.

(iii). Addiction is a primary, chronic, neurobiologic disease, with genetic, psychological, and environmental factors influencing its development and manifestations. It is a behavioral pattern of drug craving and seeking which leads to a preoccupation with drug procurement and use.

(d). Tolerance and dependence are physiological phenomena, are expected with the continued administration of opioids, and should not deter physicians from their appropriate use. Before increasing the narcotic dose due to a presumption of physiologic tolerance, the physician should review other possible causes for the decline in analgesic effect. Consideration should be given to possible new psychologic stressors or an increase in the activity of the nociceptive pathways.

(e). The use of opioids is well accepted in treating cancer pain, where nociceptive mechanisms are generally present due to ongoing tissue destruction, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In chronic non-malignant pain, by contrast, tissue destruction has generally ceased, meaning that central and neuropathic mechanisms frequently overshadow nociceptive processes. Expected survival in chronic pain is relatively long and return to a high level of function is a major goal of treatment. Therefore, approaches to pain developed in the context of malignant pain may not be transferable to chronic non-malignant pain. Opioids are generally not the best choice of medication for controlling neuropathic pain. Tricyclics and anticonvulsants should be tried first.

(f). In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. While maximum efficacy is modest, they may reduce pain sufficiently to permit adequate function. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs.

(g). Consultation or referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated.

(i). General Indications – There must be a clear understanding that opioids are to be used for a limited term in the first instance (see trial indications below), that their use is contingent upon certain obligations or goals being met by the patient, e.g., return-to-work, and the patient understands that there may be drug screening to ensure compliance.

(ii). Therapeutic Trial Indications – A therapeutic trial of opioids should not be employed unless the patient has begun or completed a full rehabilitation program. Once this criterion has been met, opioids would be indicated when a patient meets the following:

[a]. The failure of pain management alternatives, including active therapies, cognitive behavioral therapy, pain self-management techniques, and other appropriate medical techniques.

[b]. Physical and psychosocial assessment, performed by two specialists including the authorized treating physician and a specialist with expertise in chronic pain.

[c]. Informed, written, witnessed consent by the patient.

[d]. In addition, there should be documentation of sustained improvement of pain control and/or functional status, including return-to-work, with use of opioids. Frequent follow-up at least every two to four weeks may be necessary to titrate dosage and assess clinical efficacy.

(iii). On-Going, Long-Term Management – Actions should include:

[a]. Prescriptions from a single practitioner,

[b]. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects,

[c]. Ongoing effort to gain improvement of social and physical function as a result of pain relief,

[d]. Contract detailing reasons for termination of supply, with appropriate tapering of dose,

[e]. Use of random drug screening as deemed appropriate by the prescribing physician,

[f]. Use of more than two opioids: a long acting opioid for maintenance of pain relief and a short acting opioid for limited rescue use when pain exceeds the routine level. If more than two opioids are prescribed for long-term use, a second opinion from specialist who is Board Certified in Neurology, Physical Medicine and Rehabilitation, or Anesthesiology with recognized training and/or certification in pharmacological pain management is strongly recommended.

[g]. Use of acetaminophen-containing medications in patients with liver disease should be limited; and

[h]. Continuing review of overall situation with regard to nonopioid means of pain control.

[i]. Inpatient treatment in complex cases. Refer to Interdisciplinary Rehabilitation Programs for detailed information on in-patient criteria.

(iv). Relative Contraindications – Extreme caution should be used in prescribing controlled substances for workers with one or more “relative contraindications”:

[a]. History of alcohol or other substance abuse, or a history of chronic, high-dose benzodiazepine use;

[b]. off work for more than six months;

[c]. severe personality disorder

(v). General Contraindications

[a]. active alcohol or other substance abuse;

[b]. untreated mood or psychotic disorders (e.g., depression);

[c]. decreased physical or mental function with continued opioid use;

[d]. addictive behaviors. Warning signs include:

[i]. preoccupation with drugs;

[ii]. refusal to participate in medication taper;

[iii]. reporting that nothing but a specific opioid works;

[iv]. strong preference for short-acting over long-acting opioids;

{v}. use of multiple prescribers and pharmacies;

[vi]. use of street drugs or other patients drugs;  
[vii]. not taking medications as prescribed;  
[viii]. loss of medications more than once; and/or  
[ix]. criminal behaviors to obtain drugs, i.e., forged prescriptions.

(vi). Dosing and Time to Therapeutic Effect – Oral route is the preferred route of analgesic administration because it is the most convenient and cost-effective method of administration. When patients cannot take medications orally, rectal and transdermal routes should be considered because they are also relatively noninvasive.

(vii). Major Side Effects – There is great individual variation in susceptibility to opioid-induced side effects and clinicians should monitor for these potential side effects. Common initial side effects include nausea, vomiting, drowsiness, unsteadiness, and confusion. Occasional side effects include dry mouth, sweating, pruritus, hallucinations, and myoclonus. Rare side effects include respiratory depression and psychological dependence. Constipation and nausea/vomiting are common problems associated with long-term opioid administration and should be anticipated, treated prophylactically, and monitored constantly.

(viii). Drug Interactions – Patients receiving opioid agonists should not be given a mixed agonist-antagonist (pentazocine [Talwin], butorphanol [Stadol]) because doing so may precipitate a withdrawal syndrome and increase pain.

(ix). Recommended Laboratory Monitoring – Primary laboratory monitoring is recommended for acetaminophen/aspirin/NSAIDs combinations (renal and liver function, blood dyscrasias). May perform urine and/or blood drug screen if suspect use of other narcotics or lack of compliance with full medication regimen.

(x). Patient Physician Contracts – All patients on chronic opioids should have an informed, written, witnessed consent. The contract should discuss side effects of opioids, results of use in pregnancy, inability to refill lost or missing medication, withdrawal symptoms, requirement for drug testing, and necessity of tapering.

(xi). Potentiating Agents – Some medications appear to potentiate the analgesic effects of opioids. Dextromethorphan is available as a nonopioid non-prescription antitussive agent in numerous cough and cold remedies. It antagonizes N-methyl-D-aspartate receptors involved in central sensitization of pain pathways. It may exert some morphine sparing effects in patients taking morphine, but its activity as an analgesic in neuropathic pain is likely to be weak. It is well tolerated in most patients. Because the patient profiles that might predict response to dextromethorphan are undefined, its use in chronic pain must be empirically tried on an individual basis. Diphenhydramine and hydroxyzine (Atarax, Vistaril) are antihistamines, which act at H1 receptors to alleviate allergic symptoms and produce somnolence. Diphenhydramine is a component of some non-prescription sleeping preparations. Their use in potentiating the effects of analgesic drugs is not clearly defined, but it may be used empirically for this purpose.

## ix. Nonsteroidal Anti-Inflammatory Drugs

(a). Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs and the response of the individual injured worker to a specific medication is unpredictable. For this reason a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advises all NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, histamine 2 blockers, or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete blood count (CBC), liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

(i). Non-selective Nonsteroidal Anti-Inflammatory Drugs

[a]. Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

[i]. Optimal duration: one week

[ii]. Maximum duration: one year. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

(ii). Selective Cyclo-oxygenase-2 (COX-2) Inhibitors

[a]. COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency; thus, renal function may need monitoring.

[b]. COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high

risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

[i]. Optimal duration: 7 to 10 days

[ii]. Maximum duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

x. Topical Drug Delivery:

(a). Description – Topical medications may be an alternative treatment for localized musculoskeletal disorders and is an acceptable form of treatment in selected patients although there is no scientific evidence to support its use in chronic pain.

(b). Indications – Generalized musculoskeletal or joint pain. Patient selection must be rigorous to select those patients with the highest probability of compliance.

(c). Dosing and Time to Therapeutic Effect – It is necessary that all topical agents be used with strict instructions for application as well as maximum number of applications per day to obtain the desired benefit and avoid potential toxicity.

(d). Side Effects – Localized skin reactions may occur, depending on drug.

xi. Herbal/Dietary Supplements: Botanical preparations have been used for centuries to remedy human illnesses, but only recently have been subjected to systematic study. Many medications currently manufactured by pharmaceutical firms are derivatives of compounds originally isolated from plants.

(a). Clinical trials of folk remedies have been few in number, and often flawed by methodological problems. The lack of reliable data on the clinical and biological effects of herbal remedies often leads to inappropriate use. Patients commonly use non-standard remedies without discussing them with their physicians; when pharmacological interactions exist between herbs and prescription drugs, adverse effects may follow. Quality control varies between manufacturers, and because herbs are classified as dietary supplements, they are exempt from regulations governing standardization of ingredients. Physicians should ask all patients about their use of herbal medications and dietary supplements.

(i). Description – The following herbs may be appropriate for patients who prefer herbs as an alternative to prescription analgesics or NSAIDs:

[a]. White Willow Bark – There is some evidence of the effectiveness of *Salix* (willow) bark extract in chronic low back pain. A principal ingredient is salicin, with salicylic acid as the principal metabolite. In doses of 240 mg of salicin daily, willow bark extract is more effective than placebo in alleviating pain and improving scores of physical impairment. This dose is approximately equivalent to 50 mg of acetylsalicylate, which cannot alone account for its analgesic effect. It is well tolerated, with gastrointestinal complaints occurring no more frequently than with placebo. In patients at risk for GI problems from NSAID drugs, willow bark may be an appropriate option.

[b]. Devil's Claw Root – Extract of *Hapagophytum procumbens*, with the common name of devil's claw root, have been used in parts of Europe for

conditions of the musculoskeletal system, including osteoarthritis and low back pain. There is some evidence that it may relieve back pain more effectively than placebo, but functional improvement has not yet been shown. The doses used in clinical trials have consisted of 50 to 100 mg of harpagoside daily. Mild gastrointestinal upset has been reported at higher doses.

[c]. Phytodolor – A standardized extract of *Populus tremula* (aspens), *Fraxinus excelsior* (European ash), and *Solidago virgaurea* (goldenrod), Phytodolor may have anti-inflammatory properties through inhibition of cyclooxygenase pathways. In doses of up to 180 drops per day in 3 divided doses, it has shown superiority to placebo in osteoarthritis and epicondylitis when pain and grip strength were evaluated. Adverse effects were not reported to exceed those of placebo.

[d]. St. John's Wort – An herbal extract of the flowering plant *Hypericum perforatum* commonly used in the treatment of mild to moderate depression, St. John's Wort has been tested for effectiveness in neuropathic pain. There is some evidence that it lacks effectiveness on pain in polyneuropathy. The OWCA does not recommend its use as an alternative analgesic in chronic pain conditions. There is also some evidence that it is no more effective than placebo in the treatment of major depression. It should not be considered an antidepressant agent in patients requiring medical treatment of depression.

(ii). Specific Drug Interactions – Current regulations prohibit herb manufacturers from claiming that their products treat or prevent disease, but allow them to make claims about the product's effect on body function. Because herbal products are biologically active, they may interact with prescription drugs and with one another. Much of what is known concerning drug interactions is based on case reports or case series, which commonly lack crucial documentation of concomitant medication use or positive identification of herbs involved.

[a]. Physicians should be aware that patients on warfarin should have international normalized ratio (INR) measured a week after starting to take any herbal preparation.

[b]. Ginkgo, ginseng, and garlic are commonly used for reasons unrelated to relief of pain; they interfere with platelet function, and patients who take them should have bleeding times monitored.

[c]. St. John's Wort should not be combined with an SSRI, since a serotonin syndrome may result. St. John's Wort induces the CYP3A4 hepatic enzyme, lowering levels of drugs metabolized by this system; these drugs include anticonvulsants, oral contraceptives, antiretroviral, and calcium channel blockers.

[d]. Kava, often used to alleviate anxiety, may potentiate benzodiazepine anxiolytics and produce excess sedation.

[e]. Herbal preparation usage during the perioperative period should be discouraged.

xii. Other Agents:

(a). Tramadol (Ultram)

(i). Description – An opioid partial agonist that is generally well tolerated, does not cause GI ulceration, or exacerbate hypertension or congestive heart failure.

(ii). Indications – Mild to moderate pain relief. This drug has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs.

(iii). Contraindications – Use cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as MAO inhibitors, SSRIs, and TCAs. Not recommended in those with prior opioid addiction.

(iv). Side Effects – May cause impaired alertness or nausea. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation.

(v). Drug Interactions – Narcotics, sedating medications.

(vi). Recommended Laboratory Monitoring – Renal and hepatic function.

(b). Baclofen (Lioresal)

(i). Description – May be effective due to stimulation of Gamma Aminobutyric Acid (GABA) receptors.

(ii). Indications – Pain from muscle rigidity.

(iii). Side Effects – Development of ovarian cysts, exacerbation of psychotic disorders, may precipitate seizures in epileptics, dry mouth, sexual dysfunction.

(iv). Recommended Laboratory Monitoring – Renal function.

(c). Mexilitene (Mexitil)

(i). Description – An antiarrhythmic drug, which, like some anticonvulsive agents, may act on ion channels in neuronal tissue and reduce its pathological activity to a more stable level. Low concentrations may suffice to abolish impulses in damaged nerves, and mexilitene has been used successfully to treat neuropathic pain.

(ii). Indications – Neuropathic pain.

(iii). Major Contraindications – Heart disease (may depress ventricular function).

(iv). Dosing and Time to Therapeutic Effect – Titrate to therapeutic effect.

(v). Major Side Effects – Tremor, light-headedness, coordination difficulties, and nausea are common dose-related adverse effects that may be reduced by taking with food.

(vi). Drug Interactions – Lidocaine.

(vii). Recommended Laboratory Monitoring – Hepatic function, CBC. Plasma levels may also be necessary.

#### 7. Orthotics/prosthetics/equipment

a. Devices and adaptive equipment may be necessary in order to reduce impairment and disability, to facilitate medical recovery, to avoid re-aggravation of the injury, and to maintain maximum medical improvement. Indications would be to provide relief of the industrial injury or prevent further injury and include the need to control neurological and orthopedic injuries for reduced stress during functional activities. In addition, they may be used to modify tasks through instruction in the use of a device or physical modification of a device. Equipment needs may need to be reassessed periodically. Return-to-work for more detailed information.

b. Equipment may include high and low technology assistive devices, computer interface or seating, crutch or walker training, and self-care aids. It should improve safety and reduce risk of re-injury. Standard equipment to alleviate the effects of the injury on the performance of activities of daily living may vary from simple to complex adaptive devices to enhance independence and safety. Certain equipment related to cognitive impairments may also be required.

c. Ergonomic modifications may be necessary to facilitate medical recovery, to avoid re-aggravation of the injury, and to maintain maximum medical improvement. Ergonomic evaluations with subsequent recommendations may assist with the patients return-to-work. (Refer to Job Site Evaluation for further information.)

d. For chronic pain disorders, equipment such as foot orthoses or lumbar support devices may be helpful. The injured worker should be educated as to the potential harm from using a lumbar support for a period of time greater than which is prescribed. Harmful effects include de-conditioning of the trunk musculature, skin irritation, and general discomfort. Use of cervical collars is not recommended for chronic cervical myofascial pain. Special cervical orthosis and/or equipment may have a role in the rehabilitation of a cervical injury such as those injuries to a cervical nerve root resulting in upper extremity weakness or a spinal cord injury with some degree of paraparesis or tetraparesis. Use of such devices would be in a structured rehabilitation setting as part of a comprehensive rehabilitation program.

e. Fabrication/modification of orthotics, including splints, would be used when there is need to normalize weight-bearing, facilitate better motion response, stabilize a joint with insufficient muscle or proprioceptive/reflex competencies, to protect subacute conditions as needed during movement, and correct biomechanical problems. Orthotic/prosthetic training is the skilled instruction (preferably by qualified providers) in the proper use of orthotic devices and/or prosthetic limbs.

f. For information regarding specific types of orthotics/prosthetics/equipment, refer to individual medical treatment guidelines.

#### 8. Patient Education.

a. Patients should be educated on their specific injury, assessment findings, and plan of treatment and encouraged to take an active role in establishing functional outcome goals. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of rehabilitation, as well as facilitating self-management of symptoms and prevention of secondary disability. There is good evidence that patient education in self-management of asthma, anticoagulation, and other diseases improves appropriate use of medications, increases patient satisfaction with care, and reduces unscheduled physician visits for dealing with complications of treatment.

b. Patient education is an interactive process that provides an environment where the patient not only acquires knowledge but also gains an understanding of the application of that knowledge. Therefore, patients should be able to describe and/or will need to be educated on:

i. the treatment plan;

- ii. indications for and potential side effects of medications;
- iii. their home exercise program;
- iv. expected results of treatment;
- v. tests to be performed, the reasons for them and their results;
- vi. activity restrictions and return-to-work status;
- vii. home management for exacerbations of pain;
- viii. procedures for seeking care for exacerbations after office hours;
- ix. home self-maintenance program;
- x. patient responsibility to communicate with all medical providers and the employer; and
- xi. patient responsibility to keep appointments.

c. Educational efforts should also target family and other support persons, the case manager, the insurer, and the employer as indicated to optimize the understanding of the patient and the outcome. Professional translators should be provided for non-English speaking patients to assure optimum communication. All education, teaching, and instruction given to the patient should be documented in the medical record.

d. Effects of education weaken over time; continuing patient education sessions will be required to maximize the patient's function. The effectiveness of educational efforts can be enhanced through attention to the learning style and receptivity of the patient. Written educational materials may reinforce and prolong the impact of verbal educational efforts.

e. Overall, patient education should emphasize health and wellness, return-to-work and return to a productive life.

- i. Time to produce effect: Varies with individual patient
- ii. Frequency: At each visit

#### 9. Personality/psychological/psychiatric/psychosocial intervention

a. Psychosocial treatment is a generally accepted, well-established therapeutic and diagnostic procedure with selected use in acute pain problems, but with more widespread use in sub-acute and chronic pain populations. Psychosocial treatment is recommended as an important component in the total management of a patient with chronic pain and should be implemented as soon as the problem is identified. Once a diagnosis consistent with the standards of the American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders has been determined, the patient should be evaluated for the potential need for psychiatric medications. Use of any medication to treat a diagnosed condition may be ordered by the authorized treating physician, psychiatrist or medical psychologist.

b. Visits for management of psychiatric medications are medical in nature and are not a component of psychosocial treatment. Therefore, separate visits for medication management may be necessary, depending upon the patient and medications selected.

c. The screening or diagnostic workup should have clarified and distinguished between pre-existing, aggravated, and/or purely causative psychological conditions. Therapeutic and diagnostic modalities include, but are not limited to, individual counseling, and group therapy. Treatment can occur within an individualized model, a

multi-disciplinary model, or within a structured pain management program.

d. A psychologist with a PhD, PsyD, EdD credentials, Medical psychologists, or a Psychiatric MD/DO may perform psychosocial treatments. Other licensed mental health providers working in consultation with a PhD, PsyD, EdD, or Psychiatric MD/DO, and with experience in treating chronic pain disorders in injured workers may also perform treatment.

e. A status report must be provided to the authorized treating physician within two weeks of each visit to facilitate the patient's care. The report should provide documentation of progress towards functional recovery and discussion of the psychosocial issues affecting the patient's ability to participate in treatment. The report should also address pertinent issues such as pre-existing, aggravated, and/or causative, as well as project realistic functional prognosis.

- i. Time to produce effect: two to four weeks
- ii. Frequency: one to five times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly with the exception of exacerbations which may require increased frequency of visits. Not to include visits for medication management.

iii. Optimum duration: two to six months

iv. Maximum duration: 6 to 12 months, not to include visits for medication management. For select patients, longer supervised treatment may be required and, if further counseling beyond six months is indicated, functional progress must be documented.

#### 10. Restriction of activities.

a. Continuation of normal daily activities is the recommendation for chronic pain patients since immobility will negatively affect rehabilitation. Prolonged immobility results in a wide range of deleterious effects, such as a reduction in aerobic capacity and conditioning, loss of muscle strength and flexibility, increased segmental stiffness, promotion of bone demineralization, impaired disc nutrition, and the facilitation of the illness role.

b. Immobility may range from bed rest to the continued use of orthoses, such as cervical collars and lumbar support braces. While these interventions may have been ordered in the acute phase, the provider should be aware of their impact on the patient's ability to adequately comply with and successfully complete rehabilitation.

c. Patients should be educated to the detrimental effects of immobility versus the efficacious use of rest periods. Adequate rest allows the patient to comply with active treatment and benefit from the rehabilitation program. In addition complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation and promotes disability. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with chronic pain.

#### 11. Return-to-work

a. Return to work is one of the major components in chronic pain management. Return-to-work is a subject that should be addressed by each workers' compensation provider at the first meeting with the injured employee, and

be updated at each additional visit. A return-to-work format should be part of a company's health plan, knowing that return-to-work can decrease anxiety, reduce the possibility of depression, and reconnect the worker with society.

b. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset. In complex cases, experienced nurse case managers may be required to assist in return-to-work. Other services, including psychological evaluation and/or treatment and vocational assistance should be employed.

c. The following should be considered when attempting to return an injured worker with chronic pain to work.

i. Job History Interview: The authorized treating physician should perform a job history interview at the time of the initial evaluation and before any plan of treatment is established. Documentation should include the workers' job demands, stressors, duties of current job, and duties of job at the time of the initial injury. In addition, cognitive and social issues should be identified and treatment of these issues should be incorporated into the plan of care.

ii. Coordination of Care: Management of the case is a significant part of return-to-work and may be the responsibility of the authorized treating physician, occupational health nurse, risk manager, or others. Case management is a method of communication between the primary provider, referral providers, insurer, employer, and employee. Because case management may be coordinated by a variety of professionals, the case manager should be identified in the medical record.

iii. Communication: is essential between the patient, authorized treating physician, employer, and insurer. Employers should be contacted to verify employment status, job duties and demands, and policies regarding injured workers. In addition, availability of temporary and permanent restrictions, for what duration, as well as other placement options should be discussed and documented.

iv. Establishment of a Return-To-Work Status: Return-to-work for persons with chronic pain should be thought of as therapeutic, assuming that work is not likely to aggravate the basic problem or increase the discomfort. In most cases of chronic pain, the worker may not be currently working or even employed. The goal of return-to-work would be to implement a plan of care to return the worker to any level of employment with the current employer or to return them to any type of new employment.

v. Establishment of Activity Level Restrictions: A formal job description for the injured/ill employee who is employed is necessary to identify physical demands at work and assist in the creation of modified duty. A Job Site Evaluation may be utilized to identify tasks such as pushing, pulling, lifting, reaching above shoulder level, grasping, pinching, sitting, standing, posture, ambulatory distance and terrain, and if applicable, environment for temperature, air flow, noise and the number of hours that may be worked per day. Work restriction assigned by the authorized treating physician may be temporary or permanent. The case manager should continue to seek out modified work until restrictions become less cumbersome or as the worker's condition improves or deteriorates.

vi. Rehabilitation and Return-to-work: As part of rehabilitation, every attempt should be made to simulate work activities so that the authorized treating physician may promote adequate job performance. The use of ergonomic or adaptive equipment, therapeutic breaks, and interventional modalities at work may be necessary to maintain employment.

vii. Vocational Assistance: Formal vocational rehabilitation is a generally accepted intervention and can assist disabled persons to return to viable employment. Assisting patients to identify vocational goals will facilitate medical recovery and aid in the maintenance of MMI by 1) increasing motivation towards treatment and 2) alleviating the patient's emotional distress. Chronic pain patients will benefit most if vocational assistance is provided during the interdisciplinary rehabilitation phase of treatment. To assess the patient's vocational capacity, a vocational assessment may be utilized to identify rehabilitation program goals, as well as optimize both patient motivation and utilization of rehabilitation resources.

d. Recommendations to Employers and Employees of Small Businesses – Employees of small businesses who are diagnosed with chronic pain may not be able to perform any jobs for which openings exist. Temporary employees may fill those slots while the employee functionally improves. Some small businesses hire other workers and if the injured employee returns to the job, the supervisor/owner may have an extra employee. To avoid this, it is suggested that case managers be accessed through their insurer or third party insurers. Case managers may assist with resolution of these problems, as well as assist in finding modified job tasks, or find jobs with reduced hours, etc., depending upon company philosophy and employee needs.

e. Recommendations to Employers and Employees of Mid-Sized and Large Businesses – Employers are encouraged by the OWCA to identify modified work within the company that may be available to injured workers with chronic pain who are returning to work with temporary or permanent restrictions. To assist with temporary or permanent placement of the injured worker, it is suggested that a program be implemented that allows the case manager to access descriptions of all jobs within the organization.

## 12. Therapy—active.

a. The following active therapies have some evidence to support their use and are widely used and accepted methods of care for a variety of work-related injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort.

b. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). Active therapy is intended to promote independence and self-reliance in managing the physical pain as well as to improve the functional status in regard to the specific diagnosis and general conditioning and well-being. At times, a provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

c. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

d. The following active therapies are listed in alphabetical order:

i. Activities of Daily Living (ADL): are instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

(a). Time to produce effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to six weeks

(d). Maximum duration: six weeks

ii. Aquatic Therapy: is the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force of gravity applied to the body, and the pool should be large enough to allow full extremity range of motion and full erect posture. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. Indications are for individuals who may not tolerate active land-based or full weight bearing therapeutic procedures or who require augmentation of other therapy. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

(a). Time to produce effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to six weeks

(d). Maximum duration: six weeks

iii. Functional Activities: are the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, and sensory motor integration.

(a). Time to produce effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to six weeks

(d). Maximum duration: six weeks

iv. Functional Electrical Stimulation: is the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. Indications include muscle atrophy, weakness, and sluggish muscle contraction secondary to pain, injury, neuromuscular dysfunction, peripheral nerve lesion, or radicular symptoms. This modality may be prescribed for use at home when patients have demonstrated knowledge of how to self-administer and are in an independent exercise program.

(a). Time to produce effect: two to six treatments

(b). Frequency: three times per week

(c). Optimum duration: eight weeks

(d). Maximum duration: eight weeks. If beneficial, provide with home unit.

v. Lumbar Stabilization: is a therapeutic program whose goal is to strengthen the spine in its neutral and anatomic position. The stabilization is dynamic which allows whole body movements while maintaining a stabilized spine. It is the ability to move and function normally through

postures and activities without creating undue vertebral stress. Lumbar stabilization programs can be performed with or without increase in spinal axial loading, on land or in a pool. Indications include lumbar instability, lumbar mechanical pain, lumbar segmental hypermobility, spondylolisthesis, discogenic injury or pain, facet joint injury, or pain after lumbar surgery.

(a). Time to produce effect: four to eight treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to eight weeks

(d). Maximum duration: eight weeks.

vi. Neuromuscular Re-education: is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength, movement patterns, neuromuscular response, proprioception, kinesthetic sense, coordination, education of movement, balance and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(a). Time to produce effect: two to six treatments

(b). Frequency: three times per week

(c). Optimum duration: four to eight weeks

(d). Maximum duration: eight weeks

vii. Therapeutic Exercise: with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, and increased range of motion are used to promote normal movement patterns. Can also include, alternative/complementary exercise movement therapy. Therapeutic exercise programs should be tissue specific to the injury and address general functional deficits as identified in the diagnosis and clinical assessment. Patients should be instructed in and receive a home exercise program that is progressed as their functional status improves. Upon discharge, the patient would be independent in the performance of the home exercise program and would have been educated in the importance of continuing such a program. Educational goals would be to maintain or further improve function and to minimize the risk for aggravation of symptoms in the future.

(a). Time to produce effect: two to six treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to eight weeks and concurrent with an active daily home exercise program.

(d). Maximum duration: 8 to 12 weeks of

therapist oversight. Home exercise should continue indefinitely.

viii. Work Conditioning: These programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program includes, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for

patients to gain full or optimal function and return to work. The service may include the time-limited use of modalities, both active and passive, in conjunction with therapeutic exercise, functional activities, general conditioning body mechanics and lifting techniques re-training. These programs are usually initiated once re-conditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

- (a). Length of visit: one to two hours per day
- (b). Frequency: two to five visits per week
- (c). Optimum duration: two to four weeks
- (d). Maximum duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ix. Work Simulation: is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Job Site Analysis.

- (a). Length of visit: two to six hours per day
- (b). Frequency: two to five visits per week.

Optimum duration: two to four weeks

(c). Maximum duration six weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

### 13. Therapy - Passive.

a. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies to help control swelling, pain and inflammation during the rehabilitation process. They may be used intermittently as a therapist deems appropriate, or regularly if there are specific goals with objectively measured functional improvements during treatment.

b. Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and co-morbidities may extend durations of care. Having specific goals with objectively measured functional improvement during treatment can support extended durations of care. It is recommended that if after six to eight visits no treatment effect is observed, alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

c. The following passive therapies are listed in alphabetical order.

i. Electrical Stimulation (Unattended): Electrical stimulation, once applied, requires minimal on-site

supervision by the physical or nonphysical provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation.

(a). Time to produce effect: two to four treatments

(b). Frequency: Varies, depending upon indication, between two to three times per day to one time week.

(c). Optimum duration: one to three months

(d). Maximum duration: three months. Provide home unit if intended for frequent use.

ii. Infrared Therapy: is a radiant form of heat application. Indications include the need to elevate the pain threshold before exercise and to alleviate muscle spasm to promote increased movement.

(a). Time to produce effect: two to four treatments

(b). Frequency: three to five times per week

(c). Optimum duration: three weeks as primary, or intermittently as an adjunct to other therapeutic procedures up to two months

(d). Maximum duration: two months

iii. Iontophoresis: is the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholyll, hyaluronidase, salicylate), ischemia (magnesium, mecholyll, iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars and keloids (chlorine, iodine, acetate).

(a). Time to produce effect: two to six treatments

(b). Frequency: 3 times per week with at least 48 hours between treatments

(c). Optimum duration: four to six weeks

(d). Maximum duration: six weeks

iv. Manipulation: is a generally accepted, well-established and widely used therapeutic intervention for pain. Manipulation may include, but is not limited to, high velocity, low amplitude technique (adjustment, grade V mobilization, mobilization with impulse), chiropractic manipulation, osteopathic manipulation, muscle energy techniques, and non-force techniques. It is performed by taking a joint to its end range of motion and moving the articulation into the zone of accessory joint movement, well within the limits of anatomical integrity.

d. The purpose of manipulation in the treatment of chronic pain is to assess the structure and function of the patient and to identify areas of musculoskeletal dysfunction that may be causing, or contributing to, the patient's symptoms.

e. Evaluations for manipulation in the chronic pain patient should be comprehensive, taking into consideration the entire musculoskeletal system and identifying both local and remote factors in the generation of pain and dysfunction. The evaluation should be designed to isolate the presence of dysfunctional entities that will be responsive to manual medicine interventions. Results of the evaluation should assist in the differentiation of biomechanical dysfunction from anatomic pathology, as well as the clinical significance of both as possible pain generators. It is important to

consider visceral causes of somatic pain and to rule out organic disease.

f. The physical evaluation involves a direct palpatory examination to assess asymmetries of form and function; alterations in range of motion, including hypermobility and hypomobility; tissue-texture abnormalities, particularly muscular, fascial, and ligamentous structures. Special attention should be given to the presence of restrictions within the expected range of motion (hypomobility) in vertebral segments and the muscular responses to these restrictions. Extremities should also be considered in the physical evaluation. The evaluation may include use of other assessment tools such as Surface EMG, postural analysis, radiographic imaging, and imaging studies.

g. Manipulation may be indicated in patients who have not had an evaluation for manual medicine, or have not progressed adequately in an exercise program. Manipulation should be considered when there is evidence of suspicion of scoliosis, apparent leg length inequality, pelvic imbalance, facet restriction, sacroiliac dysfunction, myofascial dysfunction, gait disturbances, or postural dysfunction.

h. Indications for manipulation include joint pain, decreased joint motion and joint adhesions. Contraindications may include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of new or progressive neurologic deficits.

i. Response to treatment will depend on the appropriate application of procedures used for the clinical condition, the number of body regions involved, the chronicity of the condition, the age and general health of the patient, invasiveness of previous therapeutic interventions, and psychological factors. For chronic pain patients who have not had manipulation previously, providers should refer to the current medical treatment guidelines of the original injury for treatment and timeframe parameters. Daily treatment is usually not indicated unless they have not had any prior manipulation or they have had a recent exacerbation.

i. Time to produce effect: six to six treatments.

ii. Frequency: one to two times per week for the first two weeks as indicated by the severity of the condition. Treatment may continue at one treatment per week for the next six weeks.

iii. Optimum duration: eight weeks.

iv. Maximum duration: eight weeks. At week eight, patients should be reevaluated. Care beyond eight weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis.

v. Massage—Manual or Mechanical. Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of

acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioners hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation and flexibility prior to exercise.

(a). Time to produce effect: Immediate

(b). Frequency: one to two times per week

(c). Optimum duration: six weeks

(d). Maximum duration: two months

vi. Mobilization (Joint): is a generally well-accepted treatment consisting of passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. For further discussion on Level V joint mobilization please see section on HVLA manipulation. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy. For Level V mobilization, contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebrobasilar insufficiency, or carotid artery disease. Relative contraindications include stenosis, spondylosis, and disc herniation.

(a). Time to Produce Effect: six to nine treatments

(b). Frequency: Up to three times per week

(c). Optimum Duration: four to six weeks

(d). Maximum Duration: six weeks

vii. Mobilization (Soft Tissue): is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release, and other manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

(a). Time to Produce Effect: four to nine treatments

(b). Frequency: Up to three times per week

(c). Optimum Duration: four to six weeks

(d). Maximum Duration: six weeks

viii. Superficial Heat and Cold Therapy: Superficial heat and cold are thermal agents applied in various manners that lowers or raises the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm and

promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

- (a). Time to produce effect: Immediate
- (b). Frequency: two to five times per week
- (c). Optimum duration: three weeks as primary or intermittently as an adjunct to other therapeutic procedures up to two months
- (d). Maximum duration: two months

ix. Traction Manual. Manual traction is an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Manual traction is contraindicated in patients with tumor, infection, fracture, or fracture dislocation.

- (a). Time to produce effect: one to three sessions
- (b). Frequency: two to three times per week
- (c). Optimum duration: four weeks
- (d). Maximum duration: one month

x. Traction—Mechanical: Mechanical traction is indicated for decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response. Traction modalities are contraindicated in patients with tumor, infections, fracture, or fracture dislocation. Nonoscillating inversion traction methods are contraindicated in patients with glaucoma or hypertension.

(a). Time to produce effect: 1 to 3 sessions up to 30 minutes. If response is negative after 3 treatments, discontinue this modality.

- (b). Frequency: two to three times per week
- (c). Optimum duration: four weeks
- (d). Maximum duration: one month

xi. Transcutaneous Electrical Nerve Stimulation (TENS): should include least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation.

(a). Time to produce effect: Immediate

(b). Frequency: Variable

(c). Optimum duration: three sessions. If beneficial, provide with home unit.

(d). Maximum duration: three sessions. Purchase if effective.

xii. Ultrasound: uses sonic generators to deliver acoustic energy for therapeutic thermal and/or nonthermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation and muscle facilitation. Phonophoresis is the transfer of medication through the use of sonic generators to the target tissue to control inflammation and pain. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

- (a). Time to produce effect: 6 to 15 treatments
- (b). Frequency: three times per week
- (c). Optimum duration: four to 8 weeks
- (d). Maximum duration: two months

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

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### **§2113. Therapeutic procedures – Operative**

A. When considering operative intervention in chronic pain management, the treating physician must carefully consider the inherent risk and benefit of the procedure. All operative intervention should be based on a positive correlation with clinical findings, the clinical course, and diagnostic tests. A comprehensive assessment of these factors should have led to a specific diagnosis with positive identification of the pathologic condition.

1. Surgical procedures are seldom meant to be curative and would be employed in conjunction with other treatment modalities for maximum functional benefit. Functional benefit should be objectively measured and includes the following:

- a. return-to-work or maintaining work status;
- b. fewer restrictions at work or performing activities of daily living;
- c. decrease in usage of medications;
- d. measurable functional gains, such as increased range of motion or documented increase in strength;
- e. education of the patient should include the proposed goals of the surgery, expected gains, risks or complications, and alternative treatment

#### 2. Neurostimulation

a. Description — Neurostimulation is the delivery of low-voltage electrical stimulation to the spinal cord or peripheral nerves to inhibit or block the sensation of pain. This is a generally accepted procedure that has limited use. May be most effective in patients with chronic, intractable limb pain who have not achieved relief with oral medications, rehabilitation therapy, or therapeutic nerve blocks, and in whom the pain has persisted for longer than six months. Particular technical expertise is required to perform this procedure and is available in some neurosurgical, rehabilitation, and anesthesiology training programs and fellowships. Physicians performing this procedure must be trained in neurostimulation implantation and participate in ongoing injection training workshops, such as those sponsored by the Internal Society for Injection Studies or as sponsored by implant manufacturers.

b. Complications — May include paraplegia, epidural hematoma, epidural hemorrhage, undesirable change in stimulation, seroma, CSF leakage, infection, erosion, allergic response, hardware malfunction or equipment migration, pain at implantation site, loss of pain relief, chest wall stimulation, and other surgical risks.

c. Surgical Indications — Failure of conservative therapy including active and/or passive therapy, medication management, or therapeutic injections. Preauthorization is required. Habituation to narcotic analgesics in the absence of a history of addictive behavior does not preclude the use of neurostimulation. Only patients who meet the following criteria should be considered candidates for neurostimulation:

i. A diagnosis of a specific physical condition known to be chronically painful has been made on the basis of objective findings; and

ii. All reasonable surgical and non-surgical treatment has been exhausted; and

iii. Pre-surgical psychiatric or psychological evaluation has been performed and has demonstrated motivation and long-term commitment without issues of secondary gain; and

iv. There is no evidence of addictive behavior. (Tolerance and dependence to narcotic analgesics are not addictive behaviors and do not preclude implantation.); and

v. The topography of pain and its underlying pathophysiology are amenable to stimulation coverage (the entire painful area has been covered); and

vi. A successful neurostimulation screening test of two-three days. A screening test is considered successful if the patient (a) experiences a 50 percent decrease in pain, which may be confirmed by visual analogue scale (VAS), and (b) demonstrates objective functional gains or decreased utilization of pain medications. Functional gains may be evaluated by an occupational therapist and/or physical therapist prior to and before discontinuation of the trial.

vii. For spinal cord stimulation, a temporary lead is implanted at the level of pain and attached to an external source to validate therapy effectiveness. (For peripheral nerve screening, a nerve block is performed to define the specific nerve branch but if multiple branches are involved, a screening test for spinal cord stimulation may be indicated.) Long-term functional improvement is anticipated when objective functional improvement has been observed during time of neurostimulation screen exam.

d. Contraindications — Unsuccessful neurostimulation test – either inability to obtain functional improvement or reduction of pain, those with cardiac pacemakers, patient unable to properly operate the system. It should not be used if future MRI is planned.

e. Operative Treatment – Implantation of stimulating leads connected by extensions to either an implanted neurostimulator or an implanted receiver powered by an external transmitter. The procedure may be performed either as an open or a percutaneous procedure, depending on the presence of epidural fibrosis and the anatomical placement required for optimal efficacy.

f. Post-Operative Considerations – MRI is contraindicated after placement of neurostimulators.

g. Post-Operative Therapy – Active and/or passive therapy should be employed to improve function. Implantable stimulators will require frequent monitoring such as adjustment of the unit and replacement of batteries.

### 3. Intrathecal drug delivery

a. Description - This mode of therapy delivers small doses of medications directly into the cerebrospinal fluid. Clinical studies are conflicting regarding long-term, effective pain relief in patients with non-malignant pain. As with other routes of drug administration, escalation of dose may be required. Typically, pump refills are needed every two to three months.

b. Complications - Intrathecal delivery is associated with significant complications, such as infection, catheter disconnects, CSF leak, arachnoiditis, pump failure, nerve injury, and paralysis.

c. General Indications – The OWCA does not routinely recommend the use of Intrathecal Drug Delivery systems in injured workers with chronic pain. It may be considered only in rare cases where all other commonly used methods to control pain have failed and must be based on

preauthorization and the recommendation of at least one physician experienced in chronic pain management in consultation with the primary treating physician. Patients should only be selected for intrathecal drug delivery if they have opioid-responsive pain but cannot tolerate the effects of systemic administration. The patient must have good to excellent pain relief with a test dose using a temporary catheter prior to pump implantation. The patient must be motivated for the procedure, and must understand the potential for complications and requirements of treatment maintenance.

d. Surgical Indications – Failure of conservative therapy including active and/or passive therapy, medication management, or therapeutic injections. Only patients who meet the following criteria should be considered candidates for intraspinal analgesic infusions:

i. A diagnosis of a specific physical condition known to be chronically painful has been made on the basis of objective findings; and

ii. All reasonable surgical and non-surgical treatment has been exhausted; and

iii. Pre-surgical psychiatric or psychological evaluation has been performed and has demonstrated motivation and long-term commitment without issues of secondary gain;

iv. There is no evidence of addictive behavior. (Tolerance and dependence to narcotic analgesics are not addictive behaviors and do not preclude implantation.); and

v. A successful trial of continuous infusion by a percutaneous spinal infusion pump for a minimum of 24 hours. A screening test is considered successful if the patient experiences a 50 percent decrease in pain, which may be confirmed by VAS, and demonstrates objective functional gains or decreased utilization of pain medications. Functional gains may be evaluated by an occupational therapist and/or physical therapist prior to and before discontinuation of the trial.

e. Contraindications – Infection, body size insufficient to support the size and weight of the implanted device. Patients with other implanted programmable devices should not be given these pumps, since interference between devices may cause unintended changes in infusion rates.

### 4. Neuroablation with rhizotomy as the Exception

a. Neuroablation or neuro-destructive procedures are not commonly used in the management of non-malignant pain. These techniques require specific expertise to perform, have erratic results, and high rates of complication. Therefore, the OWCA does not recommend the use of neuroablative procedures, excepting rhizotomy, for injured workers with chronic pain.

### 5. Facet Rhizotomy

a. Description – A procedure designed to denervate the facet joint by ablating the periarticular facet nerve branches. There is good evidence to support this procedure for the cervical spine and some evidence in lumbar spine but benefits beyond one year are not yet established. Therefore, the patient should be committed to active therapy during the first post-surgical year.

b. Complications – Bleeding, infection, neural injury. There is a risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures.

c. Surgical Indications – Pain of well-documented facet origin, unresponsive to active and/or passive therapy, unresponsive to manual therapy, and in whom a psychosocial evaluation has been performed. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. All patients must have a successful response to diagnostic medial nerve branch blocks. A successful response is considered to be a 50 percent or greater relief of pain for the length of time appropriate to the local anesthetic used (i.e., bupivacaine greater than lidocaine).

d. Contraindications – Failure to obtain 50 percent or greater relief of pain with diagnostic medial branch block as well as bacterial infection – systemic or localized to region of implantation, bleeding diatheses, hematological conditions, and possible pregnancy.

e. Operative Treatment – Percutaneous radio-frequency rhizotomy is the procedure of choice over alcohol, phenol, or cryoablation. Position of the probe using fluoroscopic guidance is recommended since the maximum effective radius of the device is two millimeters.

f. Post-Operative Therapy – Active and/or passive therapy, implementation of a gentle aerobic re-conditioning program (e.g., walking) and back education within the first post-procedure week, barring complications. Instruction and participation in a long-term home-based program of ROM, strengthening, endurance and stability exercises should be done one to two weeks post procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

#### **§2115. Maintenance Management**

A. Successful management of chronic pain conditions results in fewer relapses requiring intense medical care. Failure to address long-term management as part of the overall treatment program may lead to higher costs and greater dependence on the health care system. Management of CRPS and CPD continues after the patient has met the definition of maximum medical improvement (MMI). MMI is declared when a patient's condition has plateaued and the authorized treating physician believes no further medical intervention is likely to result in improved function. When the patient has reached MMI, a physician must describe in detail the maintenance treatment.

B. Maintenance care in CRPS and CPD requires a close working relationship between the carrier, the providers, and the patient. Providers and patients have an obligation to design a cost-effective, medically appropriate program that is predictable and allows the carrier to set aside appropriate reserves. Carriers and adjusters have an obligation to assure that medical providers can design medically appropriate programs. A designated primary physician for maintenance team management is recommended.

1. Maintenance care will be based on principles of patient self-management. When developing a maintenance plan of care, the patient, physician and insurer should attempt to meet the following goals:

a. maximal independence will be achieved through the use of home exercise programs or exercise programs requiring special facilities (e.g., pool, health club) and educational programs;

b. modalities will emphasize self-management and self-applied treatment;

c. management of pain or injury exacerbations will emphasize initiation of active therapy techniques and may occasionally require anesthetic injection blocks;

d. dependence on treatment provided by practitioners other than the authorized treating physician will be minimized;

e. periodic reassessment of the patient's condition will occur as appropriate;

f. patients will understand that failure to comply with the elements of the self-management program or therapeutic plan of care may affect consideration of other interventions.

2. Home exercise programs and exercise equipment. Most patients have the ability to participate in a home exercise program after completion of a supervised exercise rehabilitation program. Programs should incorporate an exercise prescription including the continuation of an age-adjusted and diagnosis-specific program for aerobic conditioning, flexibility, stabilization, and strength. Some patients may benefit from the purchase or rental of equipment to maintain a home exercise program. Determination for the need of home equipment should be based on medical necessity to maintain MMI, compliance with an independent exercise program, and reasonable cost. Before the purchase or long-term rental of equipment, the patient should be able to demonstrate the proper use and effectiveness of the equipment. Effectiveness of equipment should be evaluated on its ability to improve or maintain functional areas related to activities of daily living or work activity. Occasionally, compliance evaluations may be made through a four-week membership at a facility offering similar equipment. Home exercise programs are most effective when done three to five times a week.

3. Exercise programs requiring special facilities Some patients may have higher compliance with an independent exercise program at a health club versus participation in a home program. All exercise programs completed through a health club facility should focus on the same parameters of an age-adjusted and diagnosis-specific program for aerobic conditioning, flexibility, stabilization, and strength. Selection of health club facilities should be limited to those able to track attendance and utilization, and provide records available for physician and insurer review. Prior to purchasing a membership, a therapist and/or exercise specialist who has treated the patient may visit the facility with the patient to assure proper use of the equipment.

a. Frequency: two to three times per week.

b. Optimal duration: one to three months.

c. Maximum maintenance duration: three months.

Continuation beyond three months should be based on functional benefit and patient compliance. Health club membership should not extend beyond three months if attendance drops below two times per week on a regular basis.

4. Patient Education Management. Educational classes, sessions, or programs may be necessary to reinforce self-management techniques. This may be performed as formal or informal programs, either group or individual.

a. Maintenance duration: two to six educational sessions during one 12-month period.

5. Psychological Management. An ideal maintenance program will emphasize management options implemented in the following order: individual self-management (pain control, relaxation and stress management, etc.); group counseling, individual counseling by a psychologist or psychiatrist; and in-patient treatment. Aggravation of the injury may require psychological treatment to restore the patient to baseline. In those cases, use treatments and timeframe parameters listed in the Biofeedback and Psychological Evaluation or Intervention sections.

a. Maintenance duration: 6 to 10 visits during one 12-month period.

6. Non-narcotic medication management. In some cases, self-management of pain and injury exacerbations can be handled with medications, such as those listed in the Medication section. Physicians must follow patients who are on any chronic medication or prescription regimen for efficacy and side effects. Laboratory or other testing may be appropriate to monitor medication effects on organ function.

a. Maintenance duration: Usually, four medication reviews within a 12-month period. Frequency depends on the medications prescribed. Laboratory and other monitoring as appropriate.

7. Narcotic Medication Management. As compared with other pain syndromes, there may be a role for chronic augmentation of the maintenance program with narcotic medications. In selected cases, scheduled medications may prove to be the most cost effective means of insuring the highest function and quality of life; however, inappropriate selection of these patients may result in a high degree of iatrogenic illness. A patient should have met the criteria in the opioids section of these guidelines before beginning maintenance narcotics. Laboratory or other testing may be appropriate to monitor medication effects on organ function. The following management is suggested for maintenance narcotics:

a. The medications should be clearly linked to improvement of function, not just pain control. All follow up visits should document the patient's ability to perform routine functions satisfactorily. Examples include the abilities to: perform work tasks, drive safely, pay bills or perform basic math operations, remain alert for 10 hours, or participate in normal family and social activities. If the patient is not maintaining reasonable levels of activity the patient should usually be tapered from the narcotic and tried on a different long acting opioid.

b. A low dose narcotic medication regimen should be defined, which may minimally increase or decrease over time. Dosages will need to be adjusted based on side effects of the medication and objective function of the patient. A patient may frequently be maintained on additional non-narcotic medications to control side effects, treat mood disorders, or control neuropathic pain; however, only one long-acting narcotic and one short acting narcotic for rescue use should be prescribed in most cases.

c. All patients on chronic narcotic medication dosages need to sign an appropriate narcotic contract with their physician for prescribing the narcotics.

d. The patient must understand that continuation of the medication is contingent on their cooperation with the maintenance program. Use of non-prescribed drugs may result in tapering of the medication. The clinician may order

random drug testing when deemed appropriate to monitor medication compliance.

e. Patients on chronic narcotic medication dosages must receive them through one prescribing physician.

i. Maintenance duration: Up to 12 visits within a 12-month period to review the narcotic plan. Laboratory and other monitoring as appropriate.

8. Therapy Management. Some treatment may be helpful on a continued basis during maintenance care if the therapy maintains objective function and decreases medication use. Aggravation of the injury may require intensive treatment to get the patient back to baseline. In those cases, treatments and timeframe parameters listed in the Active and Passive Therapy sections apply.

a. Active Therapy, Acupuncture, and Manipulation maintenance duration: 10 visits in a 12-month period.

#### 9. Injection Therapy

a. Sympathetic Blocks - These injections are considered appropriate if they maintain or increase function for a minimum of four to eight weeks. Maintenance blocks are usually combined with and enhanced by the appropriate neuropharmacological medication(s) and other care. It is anticipated that the frequency of the maintenance blocks may increase in the cold winter months or with stress.

i. Maintenance duration: Not to exceed 6 to 8 blocks in a 12-month period for a single extremity and to be separated by no less than four week intervals. Increased frequency may need to be considered for multiple extremity involvement or for acute recurrences of pain and symptoms. For treatment of acute exacerbations, consider two to six blocks with a short time interval between blocks.

b. Trigger Point Injections - These injections may occasionally be necessary to maintain function in those with myofascial problems.

i. Maintenance duration: Not more than 4 injections per session not to exceed 3 to 6 sessions per 12-month period.

c. Epidural and Selective Nerve Root Injections - Patients who have experienced functional benefits from these injections in the past may require injection for exacerbations of the condition.

i. Maintenance duration: 2 to 4 injections per 12-month period.

10. Purchase or Rental of Durable Medical Equipment. It is recognized that some patients may require ongoing use of self-directed modalities for the purpose of maintaining function and/or analgesic effect. Purchase or rental of modality based equipment should be done only if the assessment by the physician and/or therapist has determined the effectiveness, compliance, and improved or maintained function by its application. It is generally felt that large expense purchases such as spas, whirlpools, and special mattresses are not necessary to maintain function beyond the areas listed above.

a. Maintenance duration: Not to exceed 3 months for rental equipment. Purchase if effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2116. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:  
 OWCA—Medical Services  
 ATTN: Medical Director  
 P.O. Box 94040  
 Baton Rouge, LA 70804

1. Social Security No. \_-\_-
2. Date of Injury/Illness \_-\_-
3. Parts of Body Injury \_\_\_\_\_
4. Date of Birth \_-\_-
5. Date of This Request \_-\_-
6. Claim Number \_\_\_\_\_

You may attach a letter or petition with additional information with this disputed claim.  
 The information given above is true and correct to the best of my knowledge and belief.

SIGNATURE OF REQUESTING PARTY \_\_\_\_\_ DATE \_\_\_\_\_

LWC-WC 1009  
 11/2010

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by  
 \_\_\_ Employee \_\_\_ Employer \_\_\_ Insurer \_\_\_ Health Care Provider \_\_\_  
 Other \_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.

**EMPLOYEE**

8. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_

**EMPLOYEE'S ATTORNEY**

9. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER**

10. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

**INSURER/ADMINISTRATOR**

(circle one)  
 11. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER/INSURER'S ATTORNEY**

12. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

**TREATING/REQUESTING PHYSICIAN**

13. Name \_\_\_\_\_  
 Street or Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

LWC-WC 1009  
 11/2010

14. PLEASE PROVIDE A SUMMARY OF THE DETAILS REGARDING THE ISSUE AT DISPUTE:

\_\_\_\_\_  
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AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2117. Introduction**

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana's Workers' Compensation Act as injured workers with cervical spine injuries. These guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical Care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2119. General Guideline Principles**

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer, and patient through the Office of Worker's Compensation.

2. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of complex regional pain. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional

restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. Treatment parameter duration Time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

4. Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation Treatment Every three to four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic

problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated.

a. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Delayed recovery strongly considers a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline recommendations and inclusion of medical evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. *Consensus* means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. *Some* means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. *Good* means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. *Strong* means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2121. Introduction to complex regional pain syndrome

A. Complex Regional Pain Syndrome (CRPS Types I and II) describes painful syndromes, which were formerly referred to as Reflex Sympathetic Dystrophy (RSD) and causalgia. CRPS conditions usually follow injury that appears regionally and have a distal predominance of abnormal findings, exceeding the expected clinical course of the inciting event in both magnitude and duration and often resulting in significant impairment of limb function.

B. CRPS-I (RSD) is a syndrome that usually develops after an initiating noxious event, is not limited to the distribution of a single peripheral nerve, and is apparently disproportionate to the inciting event. It is associated at some point with evidence of edema, changes in skin, blood flow, abnormal sudomotor activity in the region of the pain, allodynia or hyperalgesia. The site is usually in the distal aspect of an affected extremity or with a distal to proximal gradient. The peripheral nervous system and possibly the central nervous system are involved.

C. CRPS-II (Causalgia) is the presence of burning pain, allodynia, and hyperpathia usually in the hand or foot after partial injury to a nerve or one of its major branches. Pain is within the distribution of the damaged nerve but not generally confined to a single nerve.

D. Stages seen in CRPS-I are not absolute and in fact, may not all be observed in any single patient. In some patients, stages may be missed or the patient may remain for long periods of time in one stage.

#### E. Stage 1 – Acute (Hyperemic)

1. Starts at the time of injury or even weeks later. Associated with spontaneous pain, aching, burning. Typically restricted to the distal extremity. Hyperpathia, allodynia, hypoesthesia or hyperesthesia may be present. Initially, hair and nail growth may be increased but later decrease. Skin may be warm or cold.

#### F. Stage 2 – Dystrophic (Ischemic)

1. Spontaneous burning and/or aching pain, more pronounced hyperpathia and or allodynia. Signs of chronic sympathetic over activity include reduced blood flow; sudomotor changes; increased edema; cyanotic skin; muscle wasting; decreased hair and nail growth; and osteoporosis.

#### G. Stage 3 – Atrophic

1. Signs and symptoms of this stage include pain may be less prominent; decreased hyperpathia and/or allodynia; reduction in blood flow; skin temperature and sweating may be increased or decreased; irreversible trophic changes in skin and integument; and pronounced muscle atrophy with contractures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2123. Definitions

A. *After sensation* – Refers to the abnormal persistence of a sensory perception, provoked by a stimulus even though the stimulus has ceased.

B. *Allodynia* – Pain due to a non-noxious stimulus that does not normally provoke pain.

1. *Mechanical Allodynia* – Refers to the abnormal perception of pain from usually non-painful mechanical stimulation.

2. *Static Mechanical Allodynia* – Refers to pain obtained by applying a single stimulus such as light pressure to a defined area.

3. *Dynamic Mechanical Allodynia* – Obtained by moving the stimulus such as a brush or cotton tip across the abnormal hypersensitive area.

4. *Thermal Allodynia* – Refers to the abnormal sensation of pain from usually non-painful thermal stimulation such as cold or warmth.

C. *Central Pain* – Pain initiated or caused by a primary lesion or dysfunction in the central nervous system (CNS).

D. *Central Sensitization* – The experience of pain evoked by the excitation of non-nociceptive neurons or of nerve fibers that normally relay non-painful sensations to the spinal cord. This result when non-nociceptive afferent neurons act on a sensitized CNS.

E. *Dystonia* – State of abnormal (hypo or hyper) tonicity in any of the tissues.

F. *Hyperalgesia* – Refers to an exaggerated pain response from a usually painful stimulation.

G. *Hyperemia* – Presence of increased blood in a part or organ.

H. *Hyperesthesia* (Positive Sensory Phenomenon) – Includes allodynia, hyperalgesia, and hyperpathia. Elicited by light touch, pin-prick, cold, warm vibration, joint position sensation or two-point discrimination, which is perceived as increased or more.

I. *Hyperpathia* – Refers to an abnormally painful and exaggerated reaction to stimulus, especially to a repetitive stimulus, in a patient who perceives the stimulus as less intense because of an increased threshold.

J. *Hypoesthesia* – (also hypesthesia), diminished sensitivity to stimulation.

K. *Pain Behavior* – The nonverbal actions (such as grimacing, groaning, limping, using visible pain relieving or support devices and requisition of pain medications, among others) that are outward manifestations of pain, and through which a person may communicate that pain is being experienced.

L. *Sudomotor Changes* – Alteration in function of sweat glands; sweat output may increase or decrease due to changes in autonomic input to the gland.

M. *Sympathetically Maintained Pain* (SMP) – A pain that is maintained by sympathetic efferent innervations or by circulating catecholamines.

N. *Trophic Changes* – Tissue alterations due to interruption of nerve or blood supply; may include changes in hair growth and texture of skin.

O. *Vasomotor Changes* – Alteration in regulation of dilation or constriction of blood vessels.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2125. Initial Evaluation

A. All potential pain generators should be thoroughly investigated by complete neurological and musculoskeletal exam and diagnostic procedures. Because CRPS-I is commonly associated with other injuries, it is essential that

all related diagnoses are defined and treated. These disturbances are typically restricted to one extremity, usually distally, but are variable in their expression.

1. History and physical examination (Hx& PE) The history and physical exam establish the basis for subsequent diagnostic and therapeutic procedures. When clinical evaluation findings do not complement the findings of other diagnostic procedures, clinical findings should have preference. Before the diagnosis of CRPS-I or CRPS-II is established, an experienced practitioner must perform a detailed neurological and musculoskeletal exam to exclude other potentially treatable pain generators or neurological lesions.

a. Medical History. As in other fields of medicine, a thorough patient history is an important part of the evaluation of pain. In taking such a history, factors influencing a patients' current status can be made clear and taken into account when planning diagnostic evaluation and treatment. History should ascertain the following elements:

i. Causality: How did this injury occur? Was the problem initiated by a work-related injury or exposure?

ii. Presenting symptoms:

(a). severe, generally unremitting burning and/or aching pain, and/or allodynia;

(b). swelling of the involved area;

(c). changes in skin color;

(d). asymmetry in nail and/or hair growth;

(e). abnormal sweat patterns of the involved extremity;

(f). Dystonia; and/or

(g). Subjective temperature changes of the affected area.

b. Pain History. The patient's description of and response to pain is one of the key elements in treatment. Characterization of the patient's pain and of the patient's response to pain is one of the key elements in treatment.

i. Site of Pain. Localization and distribution of the pain help determine the type of pain the patient has (i.e., central versus peripheral).

ii. Pain Drawing/Visual Analog Scale (VAS)

iii. Duration

iv. Place of onset

v. Pain Characteristics. Time of pain occurrence as well as intensity, quality and radiation give clues to the diagnosis and potential treatment.

vi. Response of Pain to Activity

vii. Associated Symptoms. Does the patient have numbness or paresthesia, dysesthesia, weakness, bowel or bladder dysfunction, decreased temperature, increased sweating, cyanosis or edema? Is there local tenderness, allodynia, hyperesthesia or hyperalgesia?

c. Substance Use/Abuse:

i. alcohol use;

ii. smoking history;

iii. History of drug use and abuse.

iv. Caffeine or caffeine-containing beverages.

d. Other Factors Affecting Treatment Outcome:

i. compensation/disability/litigation;

ii. Treatment Expectations. What does the patient expect from treatment: complete relief of pain or reduction to a more tolerable level?

e. Medical Management History. Refer to the Chronic Pain Disorder Medical Treatment Guideline's for detailed elements when performing a review of prior medical management. In addition, history may include:

i. Chronological review of medical records including previous medical evaluations and response to treatment interventions.

ii. History of diagnostic tests and results including but not limited to any response to sympathetic nerve blocks, results of general laboratory studies, EMG and nerve conduction studies, radiological examinations, including triple phase bone scan or thermography with autonomic stress testing.

iii. Medications, including prescription, over-the-counter and herbal/dietary supplements.

iv. Review of Systems check list. Determine if there is any interplay between the pain complaint and other medical conditions.

v. Psychosocial Functioning. Determine if the following are present: current symptoms of depression or anxiety, evidence of stressors in the workplace or at home, and past history of psychological problems. It is recommended that patients diagnosed with CRPS be referred for a psychosocial evaluation. All patients with CRPS have Chronic Pain, and are likely to suffer psychosocial consequences.

vi. Pre-existing Conditions. Treatment of these conditions is appropriate when the preexisting condition affects recovery from chronic pain.

f. Physical Examination. Should include examination techniques applicable to those portions of the body in which the patient is experiencing subjective symptomatology and should include:

i. Inspection. Changes in appearance of the involved area, to include trophic changes, changes in hair and nail growth, muscular atrophy, changes in skin turgor, swelling and color changes.

ii. Temperature Evaluation. Palpable temperature changes may not be detectable in early disease stages, and the examiner will generally only be able to appreciate significant temperature variations. Thermography, or other objective testing may be necessary to display temperature asymmetries.

iii. Motor Evaluation. Involuntary movements, dystonia or muscle weakness in the involved limb(s).

iv. Sensory Evaluation. A detailed sensory examination is crucial in evaluating a patient with chronic pain complaints. Presence of allodynia. Anatomic pattern of any associated sensory abnormalities to light touch, deep touch, pain and thermal stimulation. Quantitative sensory testing may be useful.

v. Musculoskeletal Evaluation. Presence of associated myofascial problems, such as contractures, ROM or trigger points.

vi. Evaluation of Nonphysiologic Findings. Determine the presence of the following: Variabilities on formal exam including variable sensory exam, inconsistent tenderness, and or swelling secondary to extrinsic sources; Inconsistencies between formal exam and observed abilities of range of motion, motor strength, gait and

cognitive/emotional state; and/or, observation of consistencies between pain behavior, affect and verbal pain rating, and affect and physical re-examination.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2127. Diagnostic Procedures**

A. Diagnostic imaging is a generally accepted, well-established, and widely used diagnostic procedure when specific indications, based on history and physical examination, are present. Physicians should refer to individual OWCA guidelines for specific information about specific testing procedures.

#### **1. Plain Film Radiography:**

a. Description. A radiological finding in CRPS may be unilateral osteoporosis; however, osteoporosis may be absent in many cases. In CRPS-I, the osteoporosis may be rapid in progression. The disorder typically affects the distal part of an extremity such as a hand or foot, yet intermediate joints such as the knee or elbow may be involved.

b. Results. The radiological appearance of osteoporosis has been characterized as spotty or patchy. Although CRPS-I may exist in the absence of osteoporosis, the diagnosis of CRPS-I cannot be made solely on the basis of radiographic appearance or the osteoporosis alone.

#### **2. Triple Phase Bone Scan:**

a. Description. Radionuclide imaging scintigraphy employing radio-pharmaceutical technetium coupled to a phosphate complex has been used to help facilitate the diagnosis of CRPS-I. It was hoped that a three-phase radionuclide study would be selective in the face of demineralization of the bone as seen in CRPS-I. However there are many different types of conditions that can produce osteoporosis and a triple-phase bone scan does not distinguish between the causes of bone demineralization.

b. Results. Clinical information can be derived from each of the three phases of the bone scan following injection. In the early course of CRPS-I, there is an increased uptake seen during Phase 1. However, in the late course of the disease process, there can actually be a decreased uptake seen. In Phase 2, which reflects the soft tissue vascularity, an increased diffuse uptake may be appreciated during the early course of CRPS-I. During Phase 3, one will see a diffuse uptake of multiple bone involvement of the involved limb, reflecting the bone turnover secondary to osteoporosis. Negative bone scans may be found in up to 40 percent of patients clinically diagnosed with CRPS-I; however when positive it may help to confirm the diagnosis of CRPS-I.

#### **B. Injections – diagnostic sympathetic**

1. Description. Diagnostic sympathetic injections are generally accepted procedures to aid in the diagnosis of CRPS I & II and SMP. Sympathetic blocks lack specificity for CRPS I & II. Each diagnostic injection has inherent risk and risk versus benefit should always be evaluated when considering injection therapy. Since these procedures are invasive, less invasive or non-invasive procedures should be considered first. Selection of patients, choice of procedure, and localization of the level for injection should be determined by clinical information.

2. Special Considerations. Injections with local anesthetics of differing duration are required to confirm a diagnosis. In some cases, injections at multiple levels may be required to accurately diagnose pain. Refer to “Injections – Therapeutic” for information on specific injections.

a. Since fluoroscopic and/or CT guidance during procedures is recommended to document technique and needle placement, an experienced physician should perform the procedure. The practitioner should have experience in ongoing injection training workshops provided by organizations such as the International Spinal Injection Society (ISIS) and be knowledgeable in radiation safety. In addition, practitioners should obtain fluoroscopy training and radiation safety credentialing from their Departments of Radiology, as applicable.

3. Complications. Complications may include transient neurapraxia, nerve injury, inadvertent spinal injection, infection, venous or arterial vertebral puncture, laryngeal paralysis, respiratory arrest, vasovagal effects, as well as permanent neurological damage.

4. Contraindications. Absolute contraindications of diagnostic injections include: bacterial infection – systemic or localized to region of injection, bleeding diatheses, hematological conditions, and possible pregnancy. Relative contraindications of diagnostic injections may include: aspirin/antiplatelet therapy (drug may be held for at least three days prior to injection).

5. Test Results. The interpretation of the test result is primarily based upon pain relief of 50 percent or greater. The diagnostic significance of the test result should be evaluated in conjunction with clinical information and further information can be obtained from functional reassessment performed by physical and/or occupational therapy or from results of other diagnostic procedures following a successful block.

a. Local anesthetics of different durations of action should be considered and could take the place of doing a "placebo" block (i.e. - procaine, lidocaine, marcaine). Pain relief should be at least 50 percent or greater for the duration of the local anesthetic. It should be noted that with CRPS-I it is not unusual for the relief to last longer than the duration of the local anesthetic. If a placebo block is done, the needle should not be placed down to the sympathetic chain nor should an injection of saline be done around the sympathetic chain. Contact with the sympathetic nerves by a needle or pressure on the chain by saline can cause a temporary sympathetic block and give a false positive placebo test. A "sham block" would be preferable to see if the patient is a placebo responder. Additionally, patients with definite CRPS-I can also be placebo responders. The fact that the patient responds positively to a placebo does not mean that he/she does not have CRPS-I. It merely means that the patient is a placebo responder. This increases the value of doing another confirmatory test.

i. Stellate Ganglion Block. For diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities secondary to CRPS-I and II. This block is commonly used for differential diagnosis and is the preferred treatment of CRPS-I pain involving the upper extremity.

(a). For diagnostic testing, use three blocks over a 3-14 day period. For a positive response, pain relief should be 50 percent or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement.

ii. Lumbar Sympathetic Block. Useful for diagnosis and treatment of pain of the pelvis and lower extremity secondary to CRPS-I and II. This block is commonly used for differential diagnosis and is the preferred treatment of sympathetic pain involving the lower extremity. For diagnostic testing, use three blocks over a 3-14 day period. For a positive response, pain relief should be 50 percent or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement.

iii. Phentolamine Infusion Test. An intravenous infusion of phentolamine, an alpha 2 blocker, which results in generalized systemic sympatholysis. The infusion begins with intravenous saline for placebo control. For a positive response, pain relief should be 50 percent or greater and associated with functional improvement. This test aids in the diagnosis of Sympathetically Maintained Pain.

#### C. Thermography (infrared stress thermography)

1. Description. A generally accepted procedure with some evidence to support its limited use. Infrared thermography may be useful for patients with suspected CRPS-I and II, and SMP. Thermography can distinguish abnormal thermal asymmetry of 1.0 degree Celsius which is not distinguishable upon physical examination. It may also be useful in cases of suspected small caliber fiber neuropathy and to evaluate patient response to sympatholytic interventions.

2. Special Considerations. The practitioner who supervises and interprets the thermographic evaluation shall follow recognized protocols and be board certified by one of the examining boards of the American Academy of Medical Infrared Imaging, American Academy of Thermology, or American Chiropractic College of Thermology.

3. Medications with anticholinergic activity (tricyclics, cyclobenzaprine, antiemetics, antipsychotics) may interfere with autonomic testing. The pre-testing protocol which includes cessation of specific medications therapy must be followed for accurate test results. Results of autonomic testing may be affected by peripheral polyneuropathy, radiculopathy or peripheral nerve injury, peripheral vascular disease, generalized autonomic failure, or by Shy-Drager syndrome.

4. Thermographic Tests. Functional autonomic stress testing may include any of the following methods:

a. Cold Water Stress Test (Cold Pressor Test). Paroxysmal cooling is strongly suggestive of vasomotor instability.

b. Warm Water Stress Test. Paroxysmal warming is strongly suggestive of vasomotor instability.

#### D. Autonomic test battery

1. Description. Resting skin temperature (RST), resting sweat output (RSO), and quantitative sudomotor axon reflex test (QSART) are a recently developed test battery with some evidence to support its limited use in the diagnosis of CRPS-I. Prior authorization is required.

2. Special Considerations. Medications with anticholinergic activity (tricyclics, cyclobenzaprine,

antiemetics, antipsychotics) may interfere with autonomic testing. Results of autonomic testing may be affected by peripheral polyneuropathy, radiculopathy or peripheral nerve injury, peripheral vascular disease, generalized autonomic failure, or by Shy-Drager syndrome.

3. Test Battery. These tests measure asymmetries in physiologic manifestations of autonomic activity between an affected limb and an unaffected contralateral limb. Skin temperature reflects vasomotor activity and sweat output measures sudomotor activity. The results of the three test components must be combined and scored. The battery of tests must include a measurement of each component (RST, RSO, and QSART).

a. Infrared Resting Skin Temperature (RST) provides thermographic measurements between the affected and unaffected limb. Generally, a 1° Celsius difference is significant.

b. Resting Sweat Output (RSO) measures an increase or reduction of 50 percent between the affected and unaffected limb.

c. Quantitative Sudomotor Axon Reflex Test (QSART) measures the sweat output elicited by iontophoretic application of acetylcholine. An increase or reduction of 50 percent between the affected and unaffected limb is significant.

E. Other diagnostic tests not specific for crps. The following tests and procedures are not used to establish the diagnosis of CRPS but may provide additional information. The following are listed in alphabetical order.

1. Electrodiagnostic Procedures. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia). Traditional electrodiagnosis includes nerve conduction studies, late responses, (F-Wave, H-reflex) and electromyographic assessment of muscles with needle electrode examination. As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies. The later development of sympathetically mediated symptomatology however, has no pathognomonic pattern of abnormality on EMG/NCS. When issues of diagnosis are in doubt, a referral or consultation with a physiatrist or neurologist trained in electrodiagnosis is appropriate.

2. Laboratory Tests are generally accepted well-established and widely used procedures and can provide useful diagnostic and monitoring information. They may be used when there is suspicion of systemic illness, infection, neoplasia, or underlying rheumatologic disorder, connective tissue disorder, or based on history and/or physical examination. Tests include, but are not limited to:

a. Complete Blood Count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects.

b. Erythrocyte sedimentation rate, rheumatoid factor, antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder, serum protein electrophoresis.

c. Thyroid, glucose and other tests to detect endocrine disorders.

d. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease.

e. urinalysis for calcium, phosphorus, hydroxyproline, or hematuria;

f. Liver and kidney function may be performed for baseline testing and monitoring of medications; and

g. Toxicology Screen and/or Blood Alcohol Level if suspected drug or alcohol abuse.

3. Peripheral Blood Flow (Laser Doppler or Xenon Clearance Techniques): This is currently being evaluated as a diagnostic procedure in CRPS-I and is not recommended by the OWCA at this time.

a. Personality/Psychosocial/Psychiatric/  
Psychological Evaluation:

i. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

ii Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

(a). employment history;

(b). interpersonal relationships-both social and work;

(c). patient activities;

(d). current perception of the medical system;

(e). current perception/attitudes toward employer/job

(f). results of current treatment

(g). Risk factors and psychological comorbidities that may influence outcome and that may require treatment.

(h). Childhood history, including history of childhood psychological trauma, abuse and family history of disability.

iii. Personality/psychological/psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians

with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

iv. Frequency. One-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

(a). Tests of Psychological Functioning

(i). Psychometric testing is a valuable component of a consultation to assist the physician in making a more effective treatment plan. Psychometric testing is useful in the assessment of mental conditions, pain conditions, cognitive functioning, treatment planning, vocational planning and evaluation of treatment effectiveness. There is no general agreement as to which standardized psychometric tests should be specifically recommended for psychological evaluations of chronic pain conditions. It is appropriate for the mental health provider to use their discretion and administer selective psychometric tests within their expertise and within standards of care in the community. Some of these tests are available in Spanish and other languages, and many are written at a 6th grade reading level.

4. Special Tests. Tests are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, strength capacity, and or physical work demands classifications and tolerance. Tests include Computer-Enhanced Evaluations, Functional Capacity Evaluation (FCE), Jobsite Evaluation, Vocational Assessment, and Work Tolerance Screening. Refer to the Chronic Pain Medical Treatment Guidelines for detailed information and frequency of each special testing procedure.

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#### **§2129. Diagnosis of CRPS**

A. Diagnostic Components of CRPS-I (RSD)

1. Subjective Complaints. Complaint of pain, usually burning or aching pain and out of proportion to identified pathology. May be sharp, or lancinating. Frequently is present without provocation or movement.

2. Physical Findings:

a. Swelling, generally unilateral and variable in presentation.

b. Vasomotor signs – Unilateral. Initial extremity warming early on, coldness of extremity as condition progresses. Discoloration of skin usually darker blue or purple, may be mottled, may be paler.

c. Sudomotor sign – Increased sweating of the involved extremity.

d. Trophic Changes – Coarse, thick hair, later may be sparse; nails brittle, ridged, may grow faster initially, later grow more slowly; skin is smooth, shiny; digits tapered (pencil pointing); joints stiff with decreased ROM; muscle wasting; motor disturbances; increased physiological tremor, dystonia.

3. Diagnostic Testing Procedures:

- a. x-rays of both extremities;
- b. triple phase bone scan;
- c. sympathetic blocks;
- d. infrared thermogram;
- e. autonomic test battery.

B. Diagnostic Criteria for CRPS

1. CRPS-I (RSD):

- a. Patient complains of pain, usually diffuse burning or aching;
- b. Patient has physical findings on examination of at least vasomotor and/or sudomotor signs. Allodynia and/or trophic changes add strength to the diagnosis of CRPS-I; and
- c. At least two diagnostic testing procedures are positive. Even the most sensitive tests can have false negatives. The patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate.

2. CRPS-II (causalgia):

- a. Patient complains of pain;
- b. Documentation of peripheral nerve injury with pain initially in the distribution of the injured nerve;
- c. Patient has physical findings on examination of at least vasomotor and/or sudomotor signs. Allodynia and/or trophic changes add strength to the diagnosis of CRPS-II; and
- d. At least two diagnostic testing procedures are positive. Even the most sensitive tests can have false negatives. The patient can still have CRPS-II, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-II, further diagnostic testing may be appropriate.

3. Sympathetically Mediated Pain (SMP):

- a. Patient complains of pain;
- b. Usually does not have clinically detectable vasomotor or sudomotor signs; and
- c. Has pain relief with sympathetic blocks.

4. Not CRPS:

- a. Patient complains of pain;
- b. May or may not have vasomotor or sudomotor signs;
- c. No relief with sympathetic blocks; and
- d. No more than one other diagnostic test procedure is positive.

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**§2131. Therapeutic Procedures – Non-Operative**

A. Non-operative therapeutic rehabilitation is applied to patients with CRPS or SMP who experience chronic and complex problems of de-conditioning and functional disability. Treatment modalities may be utilized sequentially

or concomitantly depending on chronicity and complexity of the problem, and treatment plans should always be based on a diagnosis utilizing appropriate diagnostic procedures.

B. Before initiation of any therapeutic procedure, the authorized treating physician, employer and insurer must consider these important issues in the care of the injured worker:

1. Patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to H.12 Return-to-Work for detailed information.

2. Reassessment of the patient's status in terms of functional improvement should be documented after each treatment. If patients are not responding within the recommended time periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued. Continued treatment should be monitored using objective measures such as:

- a. Return to work or maintaining work status.
- b. Fewer restrictions at work or performing or limitations in activities of daily living (ADL).
- c. Decrease in usage of medications.
- d. Measurable functional gains, such as increased range of motion or documented increase in strength.

3. Clinicians should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

4. Psychological or psychosocial screening should be performed on all chronic pain patients.

C. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation and there is some scientific evidence to support its use. Credentialed practitioners must perform acupuncture evaluations, with experience in evaluation and treatment of chronic pain patients. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. It is commonly used when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation, surgical intervention, and or as part of multidisciplinary treatment to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Refer to the Chronic Pain Medical Treatment guideline's for detailed information on acupuncture and timeframe parameters.

2. Biofeedback is a generally well-accepted form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Biofeedback treatment is intended to assist patients in managing stress-related psychophysiological reactions that may arise as a reaction to organic pain, or which may cause pain. The biofeedback specialist may utilize a variety of interventions for teaching physiological self-management. Biological feedback may

then be provided through mechanisms ranging from simple devices to electronic instrumentation, and displayed or fed back to the patient visually, auditorially, or tactilely. This enables the patient to identify and refine effective interventions.

a. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. Refer to the Chronic Pain Medical Treatment Guideline's for detailed information on biofeedback and time parameters.

3. Disturbances of sleep are common in chronic pain. Although primary insomnia may accompany pain as an independent comorbid condition, it more commonly occurs, secondary to the pain condition itself. Exacerbations of pain often are accompanied by exacerbations of insomnia; the reverse can also occur. Sleep laboratory studies have shown disturbances of sleep architecture in pain patients. Loss of deep slow-wave sleep and increase in light sleep occur and sleep efficiency, the proportion of time in bed spent asleep, is decreased. These changes are associated with patient reports of non-restorative sleep.

a. Many chronic pain patients develop behavioral habits that exacerbate and maintain sleep disturbances. Excessive time in bed, irregular sleep routine, napping, low activity and worrying in bed are all maladaptive responses that can arise in the absence of any psychopathology. There is some evidence that behavioral modification, such as patient education and group or individual counseling, can be effective in reversing the effects of insomnia. Behavioral modifications are easily implemented and can include:

- i. Maintaining a regular sleep schedule, retiring and rising at approximately the same time on weekdays and weekends.
- ii. Avoiding daytime napping.
- iii. Avoiding caffeinated beverages after lunchtime
- iv. Making the bedroom quiet and comfortable, eliminating disruptive lights, sounds television sets, and keeping a bedroom temperature of about 65°F.
- v. Avoiding alcohol or nicotine within two hours of bedtime.
- vi. Avoiding large meals within two hours of bedtime.
- vii. Exercising vigorously during the day, but not within two hours of bedtime, since this may raise core temperature and activate the nervous system.
- viii. Associating the bed with sleep and sexual activity only, using other parts of the home for television, reading and talking on the telephone.
- ix. Leaving the bedroom when unable to sleep for more than 20 minutes, returning to the bedroom when ready to sleep again.

b. These modifications should be undertaken before sleeping medication is prescribed.

4. Injections — therapeutic. When considering the use of injections in CRPS management, the treating physician must carefully consider the inherent risks and benefits. First, it is understood that these injections are seldom meant to be “curative” but may have diagnostic or prognostic qualities and when used for therapeutic purposes they are employed in conjunction with other treatment modalities for maximum benefit. Second, education of the patient should include the

proposed goals of the injections, expected gains, risks or complications, and alternative treatment. Lastly, reassessment of the patient's status in terms of functional improvement should be documented after each injection and/or series of injections.

a. Any continued use of injections should be monitored using objective measures such as:

- i. Return to work or maintaining work status.
- ii. Fewer restrictions at work or when performing activities of daily living (ADL).
- iii. Decrease in usage of medications.
- iv. Measurable functional gains, such as increased range of motion or documented increase in strength.

(a).a.

Visual analog scales (VAS) provide important subjective data but are not an appropriate measure of function.

(b).b.

The physician must be aware of the possible placebo effect as well as the long-term effects of injections related to the patient's physical and mental status. Strict adherence to contraindications, both absolute and relative, may prevent potential complications. Subjecting the patient to potential risks, i.e., needle trauma, infection, nerve injury, or systemic effects of local anesthetics and corticosteroids, must be considered before the patient consents to such procedures.

b. Sympathetic Injections:

i. Description. Sympathetic injections are generally accepted, well-established procedures. They include stellate ganglion blocks, lumbar sympathetic, and intravenous regional (Bier) blocks. Regional blocks frequently use bretylium with additional agents (narcotics and or anti-inflammatory drugs). There is some evidence that bretylium reduces pain intensity. It is recommended that all patients receiving therapeutic blocks participate in an appropriate exercise program that may include a functionally directed rehabilitation program.

ii. Indications. Pain relief and functional improvement from previous diagnostic or therapeutic blocks.

iii. Special Considerations. Except for Bier blocks, fluoroscopic and/or CT guidance during procedures is recommended to document technique and needle placement; an experienced physician should perform the procedure. The practitioner should participate in ongoing injection training workshops provided by organizations such as the International Spinal Injection Society (ISIS) and be knowledgeable in radiation safety. In addition, practitioners should obtain fluoroscopy training and radiation safety credentialing from their Departments of Radiology, as applicable.

iv. Complications may include transient neurapraxia, nerve injury, inadvertent spinal injection, infection, venous or arterial vertebral puncture, laryngeal paralysis, respiratory arrest, vasovagal effects, as well as permanent neurologic damage.

v. Contraindications. Absolute contraindications of therapeutic injections include:

- (a). bacterial infection – systemic or localized to region of injection,
- (b). bleeding diatheses,
- (c). hematological conditions, and

(d). possible pregnancy. Relative contraindications of therapeutic injections may include: aspirin/antiplatelet therapy (drug may be held for at least 3 days prior to injection).

vi. Treatment Parameters. To be effective as a treatment modality, the patient should be making measurable progress in their rehabilitation program and should be achieving an increasing or sustained duration of relief between blocks. If appropriate outcomes are not achieved, changes in treatment should be undertaken.

(a). a. Time to produce effect: one to three blocks

(b). b. Frequency: Variable, depending upon duration of pain relief and functional gains. During the first two weeks of treatment, blocks may be provided every three to five days, based on patient response. After the first two weeks, blocks may be given weekly with tapering for a maximum of seven injections over six weeks.

(c). c. Optimum duration: three months.

(d). d. Maximum duration: three to four months for initial treatment. For the use of blocks during maintenance care, refer to the Maintenance Care section for treatment parameters.

(e). c. Trigger Point Injections: May be appropriate when myofascial trigger points are present on examination. Refer to chronic pain guidelines for treatment parameters.

(f). d. Peripheral Nerve Blocks: May be appropriate when peripheral nerve pathology is identified. Refer to chronic pain guidelines for treatment parameters.

(g). e. Intravenous lidocaine: May be used as a prognostic indicator for the use of mexilitine. It is infrequently used as a therapeutic treatment.

5. Interdisciplinary rehabilitation programs are the gold standard of treatment for individuals with chronic pain who have not responded to less intensive modes of treatment. In addition, there are current studies to support the use of pain programs. There is strong evidence that interdisciplinary programs improve function in chronic pain and moderate evidence that these programs decrease pain in these patients.

a. These programs should assess the impact of pain and suffering on the patient's medical, physical, psychological, social, and/or vocational functioning. In general, interdisciplinary programs deal with irreversible, painful musculoskeletal, neurological, and other chronic painful disorders and psychological issues, including drug dependence, high levels of stress and anxiety, failed surgery and pre-existing or latent psychopathology. The number of professions involved in the team in a chronic pain program may vary due to the complexity of the needs of the person served. The OWCA recommends consideration of referral to an interdisciplinary program within 6 months post-injury in patients with delayed recovery unless surgical interventions or other medical complications intervene.

b. Chronic pain patients need to be treated within a continuum of treatment intensity. Chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated by the authorized treating physician (informal). Formal programs are able to provide coordinated, high intensity level of services and are recommended for most chronic pain patients who have received multiple therapies

during acute management. Informal programs offer a lesser intensity of service and may be considered for patients who are currently employed, those who cannot attend all day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach, methods, and goals. Generally the type of program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social and/or vocational functioning.

c. When referring a patient for formal interdisciplinary pain rehabilitation or Work Hardening programs, the OWCA recommends the programs be Commission on Accreditation of Rehabilitation Facilities (CARF) eligible and/or certified. CARF eligibility or certification ensures that programs meet specific care standards of design and efficacy.

d. Inpatient Pain Rehabilitation Programs are rarely needed but may be necessary for patients with any of the following conditions: High risk for medical instability; Moderate to severe impairment of physical/functional status; Moderate to severe pain behaviors; Moderate impairment of cognitive and/or emotional status; Dependence on medications from which he or she needs to be withdrawn; and the need for 24-hour supervised nursing.

e. Interdisciplinary pain programs, whether formal or informal, should be comprised of the following dimensions:

i. Communication. To ensure positive functional outcomes, communication between the patient, insurer and all professionals involved must be coordinated and consistent. Any exchange of information must be provided to all professionals, including the patient. Care decisions would be communicated to all.

ii. Documentation. Through documentation by all professionals involved and/or discussions with the patient, it should be clear that functional goals are being actively pursued and measured on a regular basis to determine their achievement or need for modification.

iii. Treatment Modalities. Use of modalities may be necessary early in the process to facilitate compliance with and tolerance to therapeutic exercise, physical conditioning, and increasing functional activities. Active treatments should be emphasized over passive treatments. Active treatments should encourage self-coping skills and management of pain, which can be continued independently at home or at work. Treatments that can foster a sense of dependency by the patient on the caregiver should be avoided. Treatment length should be decided based upon observed functional improvement. For a complete list of Active and Passive Therapies, refer to the Sections F.13 & 14, of this guideline. All treatment timeframes may be extended based upon the patient's positive functional improvement.

iv. Therapeutic Exercise Programs. There is strong evidence that these programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize

education, independence, and the importance of an on-going exercise regime.

v. Return-to-work. The authorized treating physician should continually evaluate the patient for their potential to return to work. When return-to-work is an option, it may be appropriate to implement a Work Hardening Program (as described in this section). For patients currently employed, efforts should be aimed at keeping them employed. For more specific information regarding return-to-work, refer to the Return-to-work section in this guideline.

vi. Patient Education. Patients with pain need to re-establish a healthy balance in lifestyle. All providers should educate patients on how to overcome barriers to resuming daily activity, including pain management, decreased energy levels, financial constraints, decreased physical ability, and change in family dynamics.

vii. Psychosocial Evaluation and Treatment. Psychosocial evaluation should be initiated, if not previously done. Providers of care should have a thorough understanding of the patient's personality profile; especially if dependency issues are involved. Psychosocial treatment may enhance the patient's ability to participate in pain treatment rehabilitation, manage stress, and increase their problem-solving and self-management skills.

viii. Vocational Assistance. Vocational assistance can define future employment opportunities or assist patients in obtaining future employment. Refer to Return-to-work section for detailed information.

f. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of the treatment program. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. The following programs are listed in order of decreasing intensity.

i. Formal Rehabilitation Programs:

(a). Interdisciplinary Pain Rehabilitation. An Interdisciplinary Pain Rehabilitation Program provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services to measure and improve the functioning of persons with pain and encourage their appropriate use of health care system and services. The program can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. The program shares information about the scope of the services and the outcomes achieved with patients, authorized providers, and insurers.

(b). The interdisciplinary team maintains consistent integration and communication to ensure that all interdisciplinary team members are aware of the plan of care for the patient, are exchanging information, and implement the plan of care. The team members make interdisciplinary team decisions with the patient and then ensure that decisions are communicated to the entire care team.

(c). The medical director of the pain program should be board certified in his or her specialty area, have at least two years full-time experience in an interdisciplinary pain rehabilitation program, and ideally be board certified in pain management. Individuals who assist in the accomplishment of functional, physical, psychological, social and vocational goal must include, at the least, a

medical director, pain physician(s), psychologist, Biofeedback Therapist, Occupational Therapist, Physical Therapist, and Registered Nurse. Other disciplines on the team may include, but are not limited to, case manager, exercise physiologist, psychiatrist, and/or nutritionist.

(i). Time to produce effect: three to four weeks

(ii). Frequency: No less than five hours/day, five days/week

(iii). Optimum duration: three to four weeks five times a week, followed by six to nine weeks of follow-up one to three times a week.

(iv). Maximum duration: Four months, including follow-up. Periodic review and monitoring thereafter on an as needed basis, is founded upon the documented maintenance of functional gains.

(d). Work Hardening is an interdisciplinary program addressing a patient's employability and return-to-work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. A full workday is case specific and is defined by the previous employment of the patient. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

(e). The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation, team physicians having experience in occupational rehabilitation, occupational therapy, physical therapy, case manager, and psychologist. As appropriate, the team may also include: chiropractor, RN, or vocational specialist.

(i). Time to produce effect: two weeks

(ii). Frequency: two to five visits per week, up to eight hours/day.

(iii). Optimum duration: two to four weeks

(iv). Maximum duration: six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Informal Rehabilitation Program: A Coordinated Interdisciplinary Pain Rehabilitation Program is one in which the authorized treating physician coordinates all aspects of care. This type of program is similar to the formal programs in that it is goal oriented and provides interdisciplinary rehabilitation services to manage the needs of the patient in the following areas: functional, medical, physical, psychological, social, and vocational.

(a). This program is different from a formal program in that it involves lesser frequency and intensity of services/treatment. Informal rehabilitation is geared toward those patients who do not need the intensity of service offered in a formal program or who cannot attend an all-day program due to employment, daycare, language or other barriers.

(b). Patients should be referred to professionals experienced in outpatient treatment of chronic pain. The OWCA recommends the authorized treating physician consult with physicians experienced in the treatment of chronic pain to develop the plan of care.

- (i). Time to produce effect: three to eight weeks
- (ii). Frequency: two to six hours per day, two to five days each week.
- (iii). Optimum duration: 6 to 12 weeks, including follow-up.
- (iv). Maximum duration: Four months, including follow-up. Periodic review and monitoring thereafter on an as needed basis, is founded upon the documented maintenance of functional gains.

6. Medications. There is no single formula for pharmacological treatment of patients with chronic nonmalignant pain. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically. Appropriate application of pharmacological agents depends on the patient's age, past history (including history of substance abuse), drug allergies, and the nature of all medical problems. It is incumbent upon the physician to thoroughly understand pharmacological principles when dealing with the different drug families and their respective side effect, bioavailability profiles and primary reason for each medication's usage.

a. Control of chronic non-malignant pain is expected to involve the use of medication. Strategies for pharmacological control of pain cannot be precisely specified in advance. Rather, drug treatment requires close monitoring of the patient's response to therapy, flexibility on the part of the prescriber, and a willingness to change treatment when circumstances change. Many of the drugs discussed in the medication section were licensed for indications other than analgesia, but are effective in the control of many types of chronic pain.

b. All medications should be given an appropriate trial in order to test for therapeutic effect. Trials of medication requiring specific therapeutic drug levels may take several months to achieve, depending upon the half-life of the drug. It is recommended that patients with CRPS be maintained on drugs that have the least serious side effects. For example, patients need to be tried or continued on acetaminophen and or antidepressant medications whenever feasible as part of their overall treatment for chronic pain. It is recommended that use of opioid analgesic and sedative hypnotic medications in chronic pain patients be used in a very limited manner, with total elimination desirable whenever clinically feasible.

c. For the clinician to interpret the following material, it should be noted that: drug profiles listed are not complete; dosing of drugs will depend upon the specific drug, especially for off-label use; and not all drugs within each class are listed, and other drugs within the class may be appropriate. Clinicians should refer to informational texts or consult a pharmacist before prescribing unfamiliar medications or when there is a concern regarding drug interactions.

d. The following drug classes are listed in alphabetical order, not in order of suggested use.

i. Anticonvulsants. Although the mechanism of action of anticonvulsant drugs in neuropathic pain states remains to be fully defined, they appear to act as nonselective sodium channel blocking agents. A large variety of sodium channels are present in nervous tissue, and some

of these are important mediators of nociception, as they are found primarily in unmyelinated fibers and their density increases following nerve injury. While the pharmacodynamic effects of the various anticonvulsant drugs are similar, the pharmacokinetic effects differ significantly. Carbamazepine has important effects as an inducer of hepatic enzymes and may influence the metabolism of other drugs enough to present problems in patients taking more than one drug. Gabapentin and oxcarbazepine, by contrast, are relatively non-significant enzyme inducers, creating fewer drug interactions. Because anticonvulsant drugs may have more problematic side-effect profiles, their use should usually be deferred until antidepressant drugs have failed to relieve pain.

(a). Gabapentin (Neurontin)

(i). Description – Structurally related to gamma aminobutyric acid (GABA) but does not interact with GABA receptors.

(ii). Indications – Neuropathic pain.

(iii). Relative Contraindications – Renal insufficiency.

(iv). Dosing and Time to Therapeutic Effect – Dosage may be increased over several days.

(v). Major Side Effects – Confusion, sedation.

(vi). Drug Interactions – Oral contraceptives, cimetidine, antacids.

(vii). Recommended Laboratory Monitoring – Renal function.

ii. Antidepressants are classified into a number of categories based on their chemical structure and their effects on neurotransmitter systems. Their effects on depression are attributed to their actions on disposition of norepinephrine and serotonin at the level of the synapse; although these synaptic actions are immediate, the symptomatic response in depression is delayed by several weeks. When used for chronic pain, the effects may in part arise from treatment of underlying depression, but may also involve additional neuromodulatory effects on endogenous opioid systems, raising pain thresholds at the level of the spinal cord.

(a). Pain responses may occur at lower drug doses with shorter times to symptomatic response than are observed when the same compounds are used in the treatment of mood disorders. Neuropathic pain, diabetic neuropathy, post-herpetic neuralgia, and cancer-related pain may respond to antidepressant doses low enough to avoid adverse effects that often complicate the treatment of depression.

(i). Tricyclics (e.g., amitriptyline [Elavil], nortriptyline [Pamelor, Aventyl], doxepin [Sinequan, Adapin])

[a]. Description – Serotonergics, typically tricyclic antidepressants (TCAs), are utilized for their serotonergic properties as increasing CNS serotonergic tone can help decrease pain perception in non-antidepressant dosages. Amitriptyline is known for its ability to repair Stage 4 sleep architecture, a frequent problem found in chronic pain patients and to treat depression, frequently associated with chronic pain.

[b]. Indications – Chronic musculoskeletal and/or neuropathic pain, insomnia. Second line drug treatment for depression.

[c]. Major Contraindications – Cardiac disease or dysrhythmia, glaucoma, prostatic hypertrophy, seizures, suicide risk.

[d]. Dosing and Time to Therapeutic Effect – Varies by specific tricyclic. Low dosages are commonly used for chronic pain and/or insomnia.

[e]. Major Side Effects – Anticholinergic side effects including, but not limited to, dry mouth, sedation, orthostatic hypotension, cardiac arrhythmia, weight gain.

[f]. Drug Interactions – Tramadol (may cause seizures), Clonidine, cimetidine, sympathomimetics, valproic acid, warfarin, carbamazepine, bupropion, anticholinergics, quinolones.

[g]. Recommended Laboratory Monitoring – Renal and hepatic function. Electrocardiogram (EKG) for those on high dosages or with cardiac risk.

iii. Hypnotics and Sedatives: Sedative and hypnotic drugs decrease activity, induce drowsiness, and moderate agitation. Many drugs produce these effects incidental to their usual intended effects, similar to the side effects of many antihistamines and antidepressants. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not routinely recommended but may be useful in some patients with chronic pain.

(a). Most insomnia in chronic pain patients should be managed primarily through behavioral interventions with medications as secondary measures (refer to Section H.4 “Disturbances of Sleep” section).

(i). Zaleplon (Sonata)

[a]. Description – A nonbenzodiazepine hypnotic.

[b]. Indications – Insomnia.

[c]. Dosing and Time to Therapeutic Effect – Time of onset is 30 to 60 minutes. Due to rapid elimination, may be taken as little as 4 hours before awakening.

[d]. Major Side Effects – Dizziness, dose-related amnesia.

[e]. Drug Interactions – Increases sedative effect of other CNS depressant drugs. Use low dose if on cimetidine.

[f]. Recommended Laboratory Monitoring – Hepatic function.

(ii). Zolpidem (Ambien)

[a]. Description – A nonbenzodiazepine hypnotic, which does not appear to cause rebound insomnia. It has little respiratory depression and insignificant anxiolytic or muscle relaxant activity.

[b]. Indications – Short-term use for insomnia

[c]. Time to Produce Therapeutic Effect – Onset of action is 30 to 60 minutes

[d]. Major Side Effects – Dizziness, dose-related amnesia.

[e]. Drug Interactions – Increases sedative effect of other CNS depressant drugs.

[f]. Recommended Laboratory Monitoring – Hepatic function.

iv. Opioids are the most powerful analgesics. Their use in acute pain and moderate to severe cancer pain is

well accepted. Their use in chronic nonmalignant pain, however, is fraught with controversy and lack of scientific research.

(a). Opioids include some of the oldest and most effective drugs used in the control of severe pain. The discovery of opioid receptors and their endogenous peptide ligands has led to an understanding of effects at the binding sites of these naturally occurring substances. Most of their analgesic effects have been attributed to their modification of activity in pain pathways within the central nervous system; however, it has become evident that they also are active in the peripheral nervous system. Activation of receptors on the peripheral terminals of primary afferent nerves can mediate antinociceptive effects, including inhibition of neuronal excitability and release of inflammatory peptides. Some of their undesirable effects on inhibiting gastrointestinal motility are peripherally mediated by receptors in the bowel wall.

(b). The central nervous system actions of these drugs account for much of their analgesic effect and for many of their other actions, such as respiratory depression, drowsiness, mental clouding, reward effects, and habit formation. With respect to the latter, it is crucial to distinguish between three distinct phenomena: tolerance, dependence, and addiction.

(c). Tolerance refers to a state of adaptation in which exposure to a drug over time causes higher doses of that drug to be required in order to produce the same physiologic effect.

(d). Dependence refers to a set of disturbances in body homeostasis that leads to withdrawal symptoms, which can be produced with abrupt discontinuation, rapid reduction, decreasing blood levels, and /or by administration of an antagonist.

(e). Addiction is a primary, chronic, neurobiologic disease, with genetic, psychological, and environmental factors influencing its development and manifestations. It is a behavioral pattern of drug craving and seeking which leads to a preoccupation with drug procurement and use.

(f). Tolerance and dependence are physiological phenomena, are expected with the continued administration of opioids, and should not deter physicians from their appropriate use.

(g). The use of opioids is well accepted in treating cancer pain, where nociceptive mechanisms are generally present due to ongoing tissue destruction, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In chronic non-malignant pain, by contrast, tissue destruction has generally ceased, meaning that central and neuropathic mechanisms frequently overshadow nociceptive processes. Expected survival in chronic pain is relatively long and return to a high level of function is a major goal of treatment. Therefore, approaches to pain developed in the context of malignant pain may not be transferable to chronic non-malignant pain.

(h). In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. While maximum efficacy is modest, they may reduce pain sufficiently to permit adequate function. When these drugs do not satisfactorily reduce pain, opioids for moderate to

moderately severe pain may be added to (not substituted for) the less efficacious drugs.

(i). Consultation or referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated.

(i). General Indications – There must be a clear understanding that opioids are to be used for a limited term in the first instance (see trial indications below), that their use is contingent upon certain obligations or goals being met by the patient, e.g., return to work, and the patient understands that there may be drug screening to ensure compliance.

(ii). Therapeutic Trial Indications – A therapeutic trial of opioids should not be employed unless the patient has begun a rehabilitation program. Once this criterion has been met, opioids would be indicated when a patient meets the following:

[a]. The failure of pain management alternatives, including active therapies, cognitive behavioral therapy, pain self-management techniques, and other appropriate medical techniques.

[b]. Physical and psychosocial assessment, performed by two specialists with one being the authorized treating physician.

[c]. Informed, written, witnessed consent by the patient.

[i]. In addition, there should be documentation of sustained improvement of pain control and/or functional status, including return to work, with use of opioids. Frequent follow-up at least every two to four weeks may be necessary to titrate dosage and assess clinical efficacy.

(iii). On-Going, Long-Term Management – Actions should Include:

[a]. Prescriptions from a single practitioner.

[b]. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.

[c]. Ongoing effort to gain improvement of social and physical function as a result of pain relief.

[d]. Contract detailing reasons for termination of supply, with appropriate tapering of dose.

[e]. Use of random drug screening, as deemed appropriate by the prescribing physician.

[f]. Use of more than two opioids. A long acting opioid for maintenance of pain relief and a short acting opioid for limited rescue use when pain exceeds the routine level. If more than two opioids are prescribed for long-term use a second opinion from specialist who is Board Certified in Neurology, Physical Medicine and Rehabilitation, or Anesthesiology with recognized training and/or certification in pharmacological pain management is strongly recommended.

[g]. Use of acetaminophen-containing medications in patients with liver disease should be limited; and

[h]. Continuing review of overall situation with regard to nonopioid means of pain control.

[i]. Inpatient treatment in complex cases. Refer to Interdisciplinary Rehabilitation Programs for detailed information on in-patient criteria.

(iv). Relative Contraindications – Extreme caution should be used in prescribing controlled substances for workers with one or more “relative contraindications”:

[a]. History of alcohol or other substance abuse, or a history of chronic, high-dose benzodiazepine use;

[b]. Off work for more than six months;

[c]. Severe personality disorder.

(v). General Contraindications –

[a]. Active alcohol or other substance abuse.

[b]. Untreated mood or psychotic disorders (e.g., depression).

[c]. Decreased physical or mental function with continued opioid use.

[d]. Addictive behaviors. Warning signs include:

[i]. Preoccupation with drugs;

[ii]. Refusal to participate in medication taper.

[iii]. Reporting that nothing but a specific opioid works;

[iv]. Strong preference for short-acting over long-acting opioids.

[v]. Use of multiple prescribers and pharmacies.

[vi]. Use of street drugs or other patients drugs.

[vii]. Not taking medications as prescribed.

[viii]. Loss of medications more than once; and/or

[ix]. Criminal behaviors to obtain drugs, i.e., forged prescriptions.

(vi). Dosing and Time to Therapeutic Effect. Oral route is the preferred route of analgesic administration because it is the most convenient and cost-effective method of administration. When patients cannot take medications orally, rectal and transdermal routes should be considered because they are also relatively noninvasive.

(vii). Major Side Effects. There is great individual variation in susceptibility to opioid-induced side effects and clinicians should monitor for these potential side effects. Common initial side effects include nausea, vomiting, drowsiness, unsteadiness, and confusion. Occasional side effects include dry mouth, sweating, pruritus, hallucinations, and myoclonus. Rare side effects include respiratory depression and psychological dependence. Constipation and nausea/vomiting are common problems associated with long-term opioid administration and should be anticipated, treated prophylactically, and monitored constantly.

(viii). Drug Interactions. Patients receiving opioid agonists should not be given a mixed agonist-antagonist (pentazocine [Talwin], butorphanol [Stadol]) because doing so may precipitate a withdrawal syndrome and increase pain.

(ix). Recommended Laboratory Monitoring. Primary laboratory monitoring is recommended for acetaminophen/aspirin/ibuprofen combinations (renal and liver function, blood dyscrasias). May perform urine and or blood drug screen if suspect use of other narcotics or lack of compliance with full medication regimen.

{x}. Patient Physician Contracts. All patients on chronic opioids should have an informed, written, witnessed consent. The contract should discuss side effects of opioids, results of use in pregnancy, inability to refill lost or missing medication, withdrawal symptoms, requirement for drug testing, and necessity of tapering.

(xi). Potentiating Agents. Some medications appear to potentiate the analgesic effects of opioids. Dextromethorphan is available as a nonopioid non-prescription antitussive agent in numerous cough and cold remedies. It antagonizes n-methyl-d-aspartate receptors involved in central sensitization of pain pathways. It may exert some morphine sparing effects in patients taking morphine, but its activity as an analgesic in neuropathic pain is likely to be weak. It is well tolerated in most patients. Because the patient profiles that might predict response to dextromethorphan are undefined, its use in chronic pain must be empirically tried on an individual basis. Diphenhydramine and hydroxyzine (atarax, vistaril) are antihistamines, which act at H 1 receptors to alleviate allergic symptoms and produce somnolence. Diphenhydramine is a component of some non-prescription sleeping preparations. Their use in potentiating the effects of analgesic drugs is not clearly defined, but it may be used empirically for this purpose.

v. Topical Drug Delivery:

(a). Description. Topical medications, such as ketamine and capsaicin, may be an alternative treatment for neuropathic disorders and is an acceptable form of treatment in selected patients although there is no literature addressing its use in patients with CRPS.

(b). Indications. Pain. Patient selection must be rigorous to select those patients with the highest probability of compliance.

(c). Dosing and Time to Therapeutic Effect. It is necessary that all topical agents be used with strict instructions for application as well as maximum number of applications per day to obtain the desired benefit and avoid potential toxicity.

(d). Side Effects. Localized skin reactions may occur, depending on drug.

vi. Other Agents:

(a). Tramadol (Ultram)

(i). Description. An opioid partial agonist that is generally well tolerated, does not cause GI ulceration, or exacerbate hypertension or congestive heart failure.

(ii). Indications. Mild to moderate pain relief. This drug has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs.

(iii). Contraindications. Use cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as monoamine oxidase (MAO) inhibitors, selective serotonin reuptake inhibitors (SSRIs), and tricyclic antidepressants (TCAs). Not recommended in those with prior opioid addiction.

(iv). Side Effects. May cause impaired alertness or nausea. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation.

(v). Drug Interactions. Narcotics, sedating medications.

(vi). Recommended Laboratory Monitoring. Renal and hepatic function.

(b). Agents not listed which may be useful in the treatment of CRPS and SMP include propranolol, nifedipine, calcitonin, bisphosphonates and short-term oral steroids, during the acute phase of the disease. Although propranolol, nifedipine, oral steroids, and calcitonin are used in practice, at this time there is a lack of well-designed studies to support their effectiveness compared to placebo. In individual patients, they may be effective. There is some evidence to support the use of intravenous bisphosphonate drugs, currently licensed for use in malignant bone disease and Paget's disease, in CRPS patients with abnormal bone scans. Oral use of bisphosphonates has not been studied in CRPS.

7. Orthotics/prosthetics/equipment. Devices and adaptive equipment may be necessary in order to reduce impairment and disability, to facilitate medical recovery, to avoid re-aggravation of the injury, and to maintain maximum medical improvement. Refer to the Chronic Pain Medical Treatment Guidelines for detailed information on Orthotics/Prosthetics/Equipment.

8. Patient education. Patients should be educated on their specific injury, assessment findings, and plan of treatment and encouraged to take an active role in establishing functional outcome goals. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of rehabilitation, as well as facilitating self-management of symptoms and prevention of secondary disability. There is good evidence that patient education in self-management of asthma, anticoagulation, and other diseases improves appropriate use of medications, increases patient satisfaction with care, and reduces unscheduled physician visits for dealing with complications of treatment.

a. Patient education is an interactive process that provides an environment where the patient not only acquires knowledge but also gains an understanding of the application of that knowledge. Therefore, patients should be able to describe and/or will need to be educated on:

- i. The treatment plan.
  - ii. Indications for and potential side effects of medications.
  - iii. Their home exercise program.
  - iv. Expected results of treatment.
  - v. Tests to be performed, the reasons for them and their results.
  - vi. Activity restrictions and return-to-work status.
  - vii. Home management for exacerbations of pain.
  - viii. Procedures for seeking care for exacerbations after office hours.
  - ix. Home self-maintenance program.
  - x. Patient responsibility to communicate with all medical providers and the employer; and
  - xi. Patient responsibility to keep appointments.
- b. Educational efforts should also extend to family and other support persons, the case manager, the insurer and

the employer as indicated to optimize the understanding of the patient and the outcome. Professional translators should be provided for non-English speaking patients to assure optimum communication. All education, teaching, and instruction given to the patient should be documented in the medical record.

c. Effects of education weaken over time; continuing patient education sessions will be required to maximize the patient's function. The effectiveness of educational efforts can be enhanced through attention to the learning style and receptivity of the patient. Written educational materials may reinforce and prolong the impact of verbal educational efforts. Overall, patient education should emphasize health and wellness, return to work and return to a productive life.

i. Time to produce effect: Varies with individual patient

ii. Frequency: At each visit

9. Personality/psychological/psychiatric/ psychosocial intervention. Psychosocial treatment is generally accepted, well-established therapeutic and diagnostic procedure with selected use in acute pain problems, but with more widespread use in sub-acute and chronic pain populations. Psychosocial treatment is recommended as an important component in the total management of a patient with chronic pain and should be implemented as soon as the problem is identified.

a. Once a diagnosis consistent with the standards of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) has been determined, the patient should be evaluated for the potential need for psychiatric medications. Use of any medication to treat a diagnosed condition may be ordered by the authorized treating physician or by the consulting psychiatrist and/or medical psychologists. Visits for management of psychiatric medications are medical in nature and are not a component of psychosocial treatment. Therefore, separate visits for medication management may be necessary, depending upon the patient and medications selected.

b. The screening or diagnostic workup should have clarified and distinguished between preexisting, aggravated, and or purely causative psychological conditions. Therapeutic and diagnostic modalities include, but are not limited to, individual counseling, and group therapy. Treatment can occur within an individualized model, a multi-disciplinary model, or within a structured pain management program.

c. Refer to Chronic Pain guideline for detailed information on whom may perform the service and timeframe parameters.

10. Restriction of activities. Continuation of normal daily activities is the recommendation for chronic pain patients since immobility will negatively affect rehabilitation. Prolonged immobility results in a wide range of deleterious effects, such as a reduction in aerobic capacity and conditioning, loss of muscle strength and flexibility, increased segmental stiffness, promotion of bone demineralization, impaired disc nutrition, and the facilitation of the illness role.

a. Patients should be educated to the detrimental effects of immobility versus the efficacious use of rest periods. Adequate rest allows the patient to comply with

active treatment and benefit from the rehabilitation program. In addition, complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation and promotes disability. Modified return to work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with chronic pain.

11. Return-to-work is one of the major components in chronic pain management. Return to work is a subject that should be addressed by each workers' compensation provider at the first meeting with the injured employee, and be updated at each additional visit. A return to work format should be part of a company's health plan, knowing that return to work can decrease anxiety, reduce the possibility of depression, and reconnect the worker with society.

a. Because a prolonged period of time off work will decrease the likelihood of return to work, the first weeks of treatment are crucial in preventing and/or reversing chronicity and disability mindset. In complex cases, experienced nurse case managers may be required to assist in return to work. Other services, including psychological evaluation and/or treatment and vocational assistance should be employed.

b. The following should be considered when attempting to return an injured worker with chronic pain to work.

i. Job History Interview. The authorized treating physician should perform a job history interview at the time of the initial evaluation and before any plan of treatment is established. Documentation should include the workers' job demands, stressors, duties of current job, and duties of job at the time of the initial injury. In addition, cognitive and social issues should be identified and treatment of these issues should be incorporated into the plan of care.

ii. Coordination of Care. Management of the case is a significant part of return to work and may be the responsibility of the authorized treating physician, occupational health nurse, risk manager, or others. Case management is a method of communication between the primary provider, referral providers, insurer, employer and employee. Because case management may be coordinated by a variety of professionals, the case manager should be identified in the medical record.

iii. Communication is essential between the patient, authorized treating physician, employer and insurer. Employers should be contacted to verify employment status, job duties and demands, and policies regarding injured workers. In addition, availability of temporary and permanent restrictions, for what duration, as well as other placement options should be discussed and documented.

iv. Establishment of a Return-To-Work Status. Return to work for persons with chronic pain should be thought of as therapeutic, assuming that work is not likely to aggravate the basic problem or increase the discomfort. In most cases of chronic pain, the worker may not be currently working or even employed. The goal of return to work would be to implement a plan of care to return the worker to any level of employment with the current employer or to return them to any type of new employment.

v. Establishment of Activity Level Restrictions. A formal job description for the injured/ill employee who is employed is necessary to identify physical demands at work

and assist in the creation of modified duty. A jobsite evaluation may be utilized to identify tasks such as pushing, pulling, lifting, reaching above shoulder level, grasping, pinching, sitting, standing, posture, ambulatory distance and terrain, and if applicable, environment for temperature, air flow, noise and the number of hours that may be worked per day. Work restrictions assigned by the authorized treating physician may be temporary or permanent. The case manager should continue to seek out modified work until restrictions become less cumbersome or as the worker's condition improves or deteriorates.

vi. Rehabilitation and Return to Work. As part of rehabilitation, every attempt should be made to simulate work activities so that the authorized treating physician may promote adequate job performance. The use of ergonomic or adaptive equipment, therapeutic breaks, and interventional modalities at work may be necessary to maintain employment.

vii. Vocational Assistance. Formal vocational assistance is a generally accepted intervention and can assist disabled persons to return to viable employment. Assisting patients to identify vocational goals will facilitate medical recovery and aid in the maintenance of MMI by increasing motivation towards treatment and alleviating the patient's emotional distress. Chronic pain patients will benefit most if vocational assistance is provided during the interdisciplinary rehabilitation phase of treatment. To assess the patient's vocational capacity, a vocational assessment may be utilized to identify rehabilitation program goals, as well as optimize both patient motivation and utilization of rehabilitation resources.

(a). Employers and employees of small businesses who are diagnosed with chronic pain may not be able to perform any jobs for which openings exist. Temporary employees may fill those slots while the employee functionally improves. Some small businesses hire other workers and if the injured employee returns to the job, the supervisor/owner may have an extra employee. To avoid this, it is suggested that case managers be accessed through their insurer or third party insurers. Case managers may assist with resolution of these problems, as well as assist in finding modified job tasks, or find jobs with reduced hours, etc., depending upon company philosophy and employee needs.

(b). Employers and employees of mid-sized and large businesses are encouraged by the OWCA to identify modified work within the company that may be available to injured workers with chronic pain who are returning to work with temporary or permanent restrictions. To assist with temporary or permanent placement of the injured worker, it is suggested that a program be implemented that allows the case manager to access descriptions of all jobs within the organization.

12. Therapy — active is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort.

a. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Active therapy is intended to promote independence and

self-reliance in managing the physical pain as well as to improve the functional status in regard to the specific diagnosis and general conditioning and well-being. At times, a provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

b. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

c. Since CRPS and SMP patients frequently have additional myofascial pain generators, other active therapies not listed may be used in treatment. Refer to the Chronic Pain Medical Treatment Guideline for therapies and timeframe parameters not listed. The following active therapies are listed in alphabetical order:

i. Activities of Daily Living (ADL) Activities of daily living are instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking and driving.

(a). Time to produce effect: four to five treatments

(b). Frequency: three to five times per week

(c). Optimum duration: four to six weeks

(d). Maximum duration: six weeks

ii. Aquatic Therapy is the implementation of active therapeutic procedures (individual or group) in a swimming or therapeutic pool heated to 88-92 degrees. The water provides a buoyancy force that lessens the amount of force gravity applies to the body, and the pool should be large enough to allow full extremity range of motion and full erect posture. The decreased gravity effect allows the patient to have a mechanical advantage increases the likelihood of successful therapeutic exercise. Multiple limb involvement, weight bearing problems, and vasomotor abnormalities are frequently treated with water exercise. Indications for individuals who may not tolerate active land-based or full weight bearing therapeutic procedures or who require augmentation or other therapy. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

(a). Time to produce effect: 5 to 10 sessions

(b). Frequency: one to three times per week

(c). Optimum duration: four to six weeks

(d). Maximum duration: Six weeks. Multiple limb involvement may require longer intervention.

iii. Gait Training. Indications include the need to promote normal gait pattern with assistive devices and/or to reduce risk of fall or loss of balance. This may include instruction in safety and proper use of assistive devices and gait instruction on uneven surfaces and steps (with or without railings).

(a). Time to produce effect: one to six sessions

(b). Frequency: one to three times per week

(c). Optimum duration: two weeks. Could be needed intermittently as changes in functional status occur.

(d). Maximum duration: one month.

iv. Neuromuscular Re-education is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength, movement

patterns, neuromuscular response, proprioception, kinesthetic sense, coordination, education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

- (a). Time to produce effect: six treatments
- (b). Frequency: one to three times per week
- (c). Optimum duration: four to eight weeks
- (d). Maximum Duration: 8 to 12 weeks

v. Stress Loading is considered a reflex and sensory integration technique involving the application of a compressive load and a carry load. It is carried out in a consistent, progressive manner and integrated as part of a home program. Use of this technique may increase symptoms initially, but symptoms generally subside with program consistency.

- (a). Time to produce effect: three weeks
- (b). Frequency: two to three times per week.
- (c). Optimum duration: Four to six weeks and concurrent with an active daily home exercise program.
- (d). Maximum Duration: 6 to 10 weeks

vi. Therapeutic exercise with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Stress loading exercises are recommended. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, increased range of motion and are used to promote normal movement patterns. This can also include, alternative/complementary exercise movement therapy. Therapeutic exercise programs should be tissue specific to the injury and address general functional deficits as identified in the diagnosis and clinical assessment. Patients should be instructed in and receive a home exercise program that progresses as their functional status improves. Upon discharge, the patient would be independent in the performance of the home exercise program and would have been educated in the importance of continuing such a program. Educational goals would be to maintain or further improve function and to minimize the risk for aggravation of symptoms in the future.

- (a). Time to produce effect: three weeks
- (b). Frequency: one to three times per week
- (c). Optimum duration: Four to eight weeks and concurrent with an active daily home exercise program.
- (d). Maximum Duration: 8 to 12 weeks of therapist oversight. Home exercise should continue indefinitely.

13. Therapy — passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively

with active therapies to help control swelling, pain and inflammation during the rehabilitation process. They may be used intermittently as a therapist deems appropriate, or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care, and co-morbidities may extend durations of care. Having specific goals with objectively measured functional improvement during treatment can support extended durations of care. It is recommended that if after 6 to 8 visits no treatment effect is observed, alternative treatment interventions, further diagnostic studies or further consultations should be pursued.

b. Since CRPS and SMP patients frequently have additional myofascial pain generators, other passive therapies not listed may be used in treatment. Refer to the Chronic Pain Disorder Medical Treatment Guideline's for therapies and timeframe parameters not listed. The following passive therapies are listed in alphabetical order:

i. Continuous Passive Motion (CPM): is rarely indicated in CRPS but may occasionally be warranted if the patient shows signs of contracture despite active therapy.

(a). Time to produce effect: Four to six treatments

(b). Frequency: Varies, between two to three times per day and one time per week.

(c). Optimum duration: Four treatments

(d). Maximum duration: Six treatments. Provide home unit with improvement.

ii. Fluidotherapy. Used primarily for desensitization and to facilitate increased active range of motion. Thermal heat conduction and convection is advantageous for vasodilation, muscle relaxation, and preparation for stress and activity (exercise).

(a). Time to produce effect: Three treatments

(b). Frequency: Three times per week

(c). Optimum duration: Two months

(d). Maximum duration: Two months as a primary therapy or intermittently as an adjunct therapy to other procedures.

iii. Orthotics/Splinting. Static splinting is discouraged. Dynamic splinting may occasionally be useful in controlling proximal hypertonicity or for other concurrent pain generators.

(a). Time to produce effect: One week

(b). Frequency: varies depending upon application

(c). Optimum duration: One month

(d). Maximum duration: Two months

iv. Paraffin Bath. Indications include the need to enhance collagen extensibility before stretching, reduce muscle guarding, and to prepare for functional restoration activities.

(a). Time to produce effect: One to two treatments

(b). Frequency: One to three times per week as an adjunct treatment to other procedures. May use daily if available at home

(c). Optimum duration: Two weeks

(d). Maximum duration: Three to four weeks. If effective, purchase home unit.

v. Desensitization is accomplished through sensory integration techniques. Concurrent desensitization techniques are generally accepted as a treatment for CRPS. Home techniques using soft cloths of various textures, massage, and vibrators may be beneficial in reducing allodynia and similar sensory abnormalities.

(a). Time to produce effect: Six treatments

(b). Frequency: Three times per week and concurrent with home exercise program

(c). Optimum duration: Three weeks with reinforcement of home program

(d). Maximum duration: One month.

vi. Superficial Heat Therapy. Superficial heat is a thermal agent applied to raise the body tissue temperature. It is indicated before exercise to elevate the pain threshold, alleviate muscle spasm, and promote increased movement. Heat packs can be used at home as an extension of therapy in the clinic setting.

(a). Time to produce effect: Immediate

(b). Frequency: One to three times per week

(c). Optimum duration: Two weeks as primary or intermittently as an adjunct to other therapeutic procedures.

(d). Maximum duration: Two weeks. Home use as a primary modality may continue at the providers' discretion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2133. Therapeutic Procedures – Operative**

A. When considering operative intervention in chronic pain management, the treating physician must carefully consider the inherent risk and benefit of the procedure. All operative intervention should be based on a positive correlation with clinical findings, the clinical course, and diagnostic tests. A comprehensive assessment of these factors should have led to a specific diagnosis with positive identification of the pathologic condition(s).

B. Surgical procedures are seldom meant to be curative and would be employed in conjunction with other treatment modalities for maximum functional benefit. Functional benefit should be objectively measured and includes the following:

1. Return to work or maintaining work status.

2. Fewer restrictions at work or performing activities of daily living (ADL).

3. Decrease in usage of medications.

4. Measurable functional gains, such as increased range of motion or documented increase in strength.

C. Education of the patient should include the proposed goals of the surgery, expected gains, risks or complications, and alternative treatment.

1. Intrathecal drug delivery. This mode of therapy delivers small doses of medications directly into the cerebrospinal fluid. Refer to the Chronic Pain Medical Treatment Guideline's for detailed information and recommendations for its use in CRPS patients with chronic pain.

2. Neurostimulation is the delivery of low-voltage electrical stimulation to the spinal cord or peripheral nerves to inhibit or block the sensation of pain. Refer to the Chronic Pain Medical Treatment Guideline's for detailed information

and recommendations for its use in CRPS patients with chronic pain.

### **3. Sympathectomy**

a. Description. Destruction of part of the sympathetic nervous system, which is not generally accepted or widely used. Long-term success with this pain relief treatment is poor. This procedure requires prior authorization.

b. Indications. Single extremity CRPS-I or SMP; distal pain only (should not be done if the proximal extremity is involved). Local anesthetic Stellate Ganglion Block or Lumbar Sympathetic Block consistently gives 90 to 100 percent relief each time a technically good block is performed (with measured rise in temperature). The procedure may be considered for individuals who have limited duration of relief from blocks. Permanent neurological complications are common.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2135. Maintenance Management**

A. Successful management of chronic pain conditions results in fewer relapses requiring intense medical care. Failure to address long-term management as part of the overall treatment program may lead to higher costs and greater dependence on the health care system. Management of CRPS and SMP continues after the patient has met the definition of maximum medical improvement (MMI). MMI is declared when a patient's condition has plateaued and the authorized treating physician believes no further medical intervention is likely to result in improved function. When the patient has reached MMI, a physician must describe in detail the maintenance treatment.

B. Maintenance care in CRPS and SMP requires a close working relationship between the carrier, the providers, and the patient. Providers and patients have an obligation to design a cost effective, medically appropriate program that is predictable and allows the carrier to set aside appropriate reserves. Carriers and adjusters have an obligation to assure that medical providers can plan medically appropriate programs. A designated primary physician for maintenance team management is recommended.

C. Maintenance Care will be based on principles of patient self-management. When developing a maintenance plan of care, the patient, physician and insurer should attempt to meet the following goals:

1. Maximal independence will be achieved through the use of home exercise programs or exercise programs requiring special facilities (e.g., pool, health club) and educational programs;

2. Modalities will emphasize self management and self-applied treatment;

3. Management of pain or injury exacerbations will emphasize initiation of active therapy techniques and may occasionally require anesthetic injection blocks.

4. Dependence on treatment provided by practitioners other than the authorized treating physician will be minimized;

5. Periodic reassessment of the patient's condition will occur as appropriate.

6. Patients will understand that failure to comply with the elements of the self-management program or therapeutic plan of care may affect consideration of other interventions.

#### D. Specific Maintenance Interventions and Parameters

1. Home exercise programs and exercise equipment. Most patients have the ability to participate in a home exercise program after completion of a supervised exercise rehabilitation program. Programs should incorporate an exercise prescription including the continuation of an age-adjusted and diagnosis-specific program for aerobic conditioning, flexibility, stabilization, and strength. Some patients may benefit from the purchase or rental of equipment to maintain a home exercise program. Determination for the need of home equipment should be based on medical necessity to maintain MMI, compliance with an independent exercise program, and reasonable cost. Before the purchase or long-term rental of equipment, the patient should be able to demonstrate the proper use and effectiveness of the equipment. Effectiveness of equipment should be evaluated on its ability to improve or maintain functional areas related to activities of daily living or work activity. Occasionally, compliance evaluations may be made through a 4-week membership at a facility offering similar equipment. Home exercise programs are most effective when done three to five times a week.

2. Exercise programs requiring special facilities. Some patients may have higher compliance with an independent exercise program at a health club versus participation in a home program. All exercise programs completed through a health club facility should focus on the same parameters of an age-adjusted and diagnosis-specific program for aerobic conditioning, flexibility, stabilization, and strength. Selection of health club facilities should be limited to those able to track attendance and utilization, and provide records available for physician and insurer review. Prior to purchasing a membership, a therapist and or exercise specialist who has treated the patient may visit the facility with the patient to assure proper use of the equipment.

a. Frequency: two to three times per week.

b. Optimal Duration: one to three months.

c. Maximum Maintenance duration: Three months.

Continuation beyond three months should be based on functional benefit and patient compliance. Health club membership should not extend beyond three months if attendance drops below two times per week on a regular basis.

3. Patient education management. Educational classes, sessions, or programs may be necessary to reinforce self-management techniques. This may be performed as formal or informal programs, either group or individual.

a. Maintenance duration: Two to six educational sessions during one 12-month period.

4. Psychological management. An ideal maintenance program will emphasize management options implemented in the following order: individual self-management (pain control, relaxation and stress management, etc.), group counseling, individual counseling by a psychologist or psychiatrist and in-patient treatment. Aggravation of the injury may require more intense psychological treatment to restore the patient to baseline. In those cases, use treatments

and timeframe parameters listed in the Biofeedback and Psychological Evaluation or Intervention sections.

a. Maintenance duration: 6 to 10 visits during one 12-month period.

5. Non-narcotic medication management. In some cases, self-management of pain and injury exacerbations can be handled with medications, such as those listed in Section H.7, Medication Section. Physicians must follow patients who are on any chronic medication or prescription regimen for efficacy and side effects. Laboratory or other testing may be appropriate to monitor medication effects on organ function.

a. Maintenance duration: Usually, four medication reviews within a 12-month period. Frequency depends on the medications prescribed. Laboratory and other monitoring as appropriate.

6. Narcotic medication management. As compared with other pain syndromes, there may be a role for chronic augmentation of the maintenance program with narcotic medications. In selected cases, scheduled medications may prove to be the most cost effective means of insuring the highest function and quality of life; however, inappropriate selection of these patients may result in a high degree of iatrogenic illness. A patient should have met the criteria in opioids section of these guidelines before beginning maintenance narcotics. Laboratory or other testing may be appropriate to monitor medication effects on organ function. The following management is suggested for maintenance narcotics:

a. The medications should be clearly linked to improvement of function, not just pain control. All follow up visits should document the patient's ability to perform routine functions satisfactorily. Examples include the abilities to: perform work tasks, drive safely, pay bills or perform basic math operations, remain alert for 10 hours, or participate in normal family and social activities. If the patient is not maintaining reasonable levels of activity the patient should usually be tapered from the narcotic and tried on a different long-acting opioid.

b. A low dose narcotic medication regimen should be defined, which may minimally increase or decrease over time. Dosages will need to be adjusted based on side effects of the medication and objective function of the patient. A patient may frequently be maintained on additional non-narcotic medications to control side effects, treat mood disorders, or control neuropathic pain; however, only one long-acting narcotic and one short-acting narcotic for rescue use should be prescribed in most cases.

c. All patients on chronic narcotic medication dosages need to sign an appropriate narcotic contract with their physician for prescribing the narcotics.

d. The patient must understand that continuation of the medication is contingent on their cooperation with the maintenance program. Use of non-prescribed drugs may result in tapering of the medication. The clinician may order random drug testing when deemed appropriate to monitor medication compliance.

e. Patients on chronic narcotic medication dosages must receive them through one prescribing physician.

i. Maintenance duration: Up to 12 visits within a 12-month period to review the narcotic plan. Laboratory and other monitoring as appropriate.



## **Chapter 22. Carpal Tunnel Syndrome (CTS) Medical Treatment Guidelines**

### **§2201. Introduction**

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana's Workers' Compensation Act as injured workers with CTS. These guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical care, services, and treatment that varies from these guidelines shall also be due by the employer when it is evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2203. General Guideline Principles**

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer, and patient through the Office of Worker's Compensation.

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of CTS. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. Treatment Parameter Duration. Time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1.

4. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-Evaluation Treatment Every three to four Weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return To Work. Return to work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full

duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Delayed recovery strongly considers a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. "*Consensus*" means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. "*Some*" means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. "*Good*" means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. "*Strong*" means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

e. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

#### **§2205. Definitions**

A. Carpal tunnel syndrome (CTS) is one of the most common mononeuropathies (a disorder involving only a single nerve). The median nerve is extremely vulnerable to compression and injury in the region of the wrist and palm. In this area, the nerve is bounded by the wrist bones and the transverse carpal ligament. The most common site of compression is at the proximal edge of the flexor retinaculum (an area near the crease of the wrist). There is often a myofascial component in the patient's presentation.

This should be considered when proceeding with the diagnostic workup and therapeutic intervention.

B. Studies have repeatedly confirmed that the diagnosis cannot be made based on any single historical factor or physical examination finding. Electrodiagnostic tests may be negative in surgically confirmed cases. Conversely, electrodiagnostic testing may be positive in asymptomatic individuals. The diagnosis of CTS, therefore, remains a clinical diagnosis based on a preponderance of supportive findings.

C. Classic findings of CTS include subjective numbness or dysesthesias confined to the median nerve distribution, worsening of symptoms at night, and positive exam findings. When the diagnosis is in question, steroid injection into the carpal tunnel is a strongly supportive test if it is followed by significant relief of symptoms.

1. Please refer to other appropriate upper extremity guidelines as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

#### **§2207. Initial Diagnostic Procedures**

A. Introduction. The two standard procedures that are to be utilized when initially evaluating a work-related carpal tunnel complaint are History Taking, and Physical Examination. History-taking and Physical Examination are generally accepted, well-established, and widely used procedures which establish the foundation/basis for and dictate all ensuing stages of diagnostic and therapeutic procedures. When findings of clinical evaluation and those of other diagnostic procedures do not complement each other, the objective clinical findings should have preference.

##### **B. History**

1. Description of symptoms should address at least the following.

a. numbness, tingling, and/or burning of the hand involving the distal median nerve distribution; however, distribution of the sensory symptoms may vary considerably between individuals. Although the classic median nerve distribution is to the palmar aspect of the thumb, the index finger, the middle finger and radial half of the ring finger, patients may report symptoms in any or all of the fingers. The Katz Hand diagram (see Fig. 1) may be useful in documenting the distribution of symptoms; the classic pattern of carpal tunnel affects at least two of the first three digits and does not involve dorsal and palmar aspects of the hand. A probable pattern involves the palmar but not dorsal aspect of the hand (excluding digits).

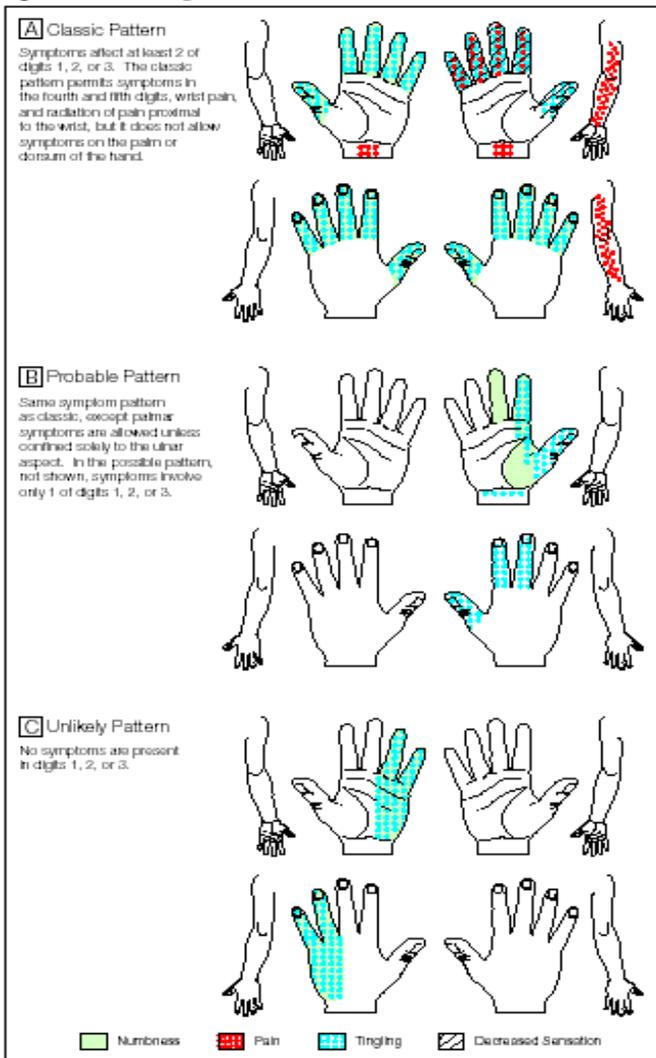
b. nocturnal symptoms frequently disrupt sleep and consist of paresthesias and/or pain in the hand and/or arm.

c. pain in the wrist occurs frequently and may even occur in the forearm, elbow or shoulder. While proximal pain is not uncommon, its presence warrants evaluation for other pathology in the cervical spine, shoulder and upper extremity.

d. the "flick sign," or shaking the symptomatic hand to relieve symptoms may be reported.

e. clumsiness of the hand or dropping objects is often reported, but may not be present early in the course.

**Figure 1. Katz Hand Diagram**



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2. Identification of Occupational Risk Factors. Job title alone is not sufficient information. The clinician is responsible for documenting specific information regarding repetition, force and other risk factors, as listed in the table entitled, 'Risk Factors Associated with CTS'- Table 2. A job site evaluation may be required.

3. Demographics. Age, hand dominance, gender, etc.

4. Past Medical History and Review of Systems. A study of CTS patients showed a 33 percent prevalence of related disease. Risk factors for CTS include female gender; obesity; Native American, Hispanic, or Black heritage, and certain medical conditions:

- Pregnancy
- Arthropathies including connective tissue disorders, rheumatoid arthritis, systemic lupus erythematosus, gout, osteoarthritis and spondyloarthropathy
- Colles' fracture or other acute trauma
- Amyloidosis
- Hypothyroidism, especially in older females
- Diabetes mellitus, including family history or gestational diabetes
- Acromegaly

- Use of corticosteroids or estrogens
- Vitamin B6 deficiency

5. Activities of Daily Living (ADLs): include such activities as self care and personal hygiene, communication, ambulation, attaining all normal living postures, travel, non-specialized hand activities, sexual function, sleep, and social and recreational activities. Specific movements in this category include pinching or grasping keys/pens/other small objects, grasping telephone receivers or cups or other similar-sized objects, and opening jars. The quality of these activities is judged by their independence, appropriateness, and effectiveness. Assess not simply the number of restricted activities but the overall degree of restriction or combination of restrictions.

6. Avocational Activities. Information must be obtained regarding sports, recreational, and other avocational activities that might contribute to or be impacted by CTD development. Activities such as hand-operated video games, crocheting/needlepoint, home computer operation, golf, racquet sports, bowling, and gardening are included in this category.

7. Social History. Exercise habits, alcohol consumption, and psychosocial factors.

C. Physical Examination . Please refer to Table 1 for respective sensitivities and specificities for findings used to diagnose CTS (a-f).

1. Sensory loss to pinprick, light touch, two-point discrimination or Semmes-Weinstein Monofilament tests in a median nerve distribution may occur.

2. Thenar atrophy may appear, but usually late in the course.

3. Weakness of the abductor pollicis brevis may be present.

4. Phalen's sign may be positive.

5. Tinel's sign over the carpal tunnel may be positive.

6. Closed Fist test – holding fist closed for 60 seconds reproduces median nerve paresthesia.

7. Evaluation of the contralateral wrist is recommended due to the frequency of bilateral involvement.

8. Evaluation of the proximal upper extremity and cervical spine for other disorders including cervical radiculopathy, thoracic outlet syndrome, other peripheral neuropathies, and other musculoskeletal disorders.

9. Signs of underlying medical disorders associated with CTS, e.g., diabetes mellitus, arthropathy, and hypothyroidism.

10. Myofascial findings requiring treatment may present in soft tissue areas near other CTD pathology, and should be documented. Refer to the Cumulative Trauma Disorder Medical Treatment Guidelines.

**Table 1: Sensitivities and Specificities and Evidence Level for Physical Examination findings**

Procedure	Sensitivity (%)	Specificity (%)	Evidence
1. Sensory testing			
Hypesthesia	15-51	85-93	Good
Katz Hand Diagram	62-89	73-88	Good
Two-point discrimination	22-33	81-100	Some
Semmes-Weinstein	52-91	59-80	Some
Vibration	20-61	71-81	None
2. Phalen's	51-88	32-86	Some
3. Tinel's	25-73	55-94	Some

Procedure	Sensitivity (%)	Specificity (%)	Evidence
4. Carpal tunnel compression	28-87	33-95	Some
5. Thenar atrophy	3-28	82-100	Good
Abductor pollicis brevis weakness	63-66	62-66	Good
6. Closed fist test	61	92	Some
7. Tourniquet test	16-65	36-87	None

D. Risk factors. A critical review of epidemiologic literature identified a number of physical exposures associated with CTS. For example, trauma and fractures of the hand and wrist may result in CTS. Other physical exposures considered risk factors include: repetition, force, vibration, pinching and gripping, and cold environment. When workers are exposed to several risk factors simultaneously, there is an increased likelihood of CTS. Not all risk factors have been extensively studied. Exposure to cold environment, for example, was not examined independently; however, there is good evidence that combined with other risk factors cold environment increases the likelihood of a CTS. Table 2 at the end of this section entitled, "Risk Factors Associated CTS," summarizes the results of currently available literature. No single epidemiologic study will fulfill all criteria for causality. The clinician must recognize that currently available epidemiologic data is based on population results, and that individual variability lies outside the scope of these studies. Many published studies are limited in design and methodology, and, thus, preclude conclusive results. Most studies' limitations tend to attenuate, rather than inflate, associations between workplace exposures and CTS. These guidelines are based on current epidemiologic knowledge. As with any scientific work, the guidelines are expected to change with advancing knowledge. The clinician should remain flexible and incorporate new information revealed in future studies.

**Table 2: Risk Factors Associated with Carpal Tunnel Syndrome**

Diagnosis: Carpal Tunnel Syndrome:	
<b>Strong evidence</b>	Combination of high exertional force (Varied from greater than 6 kg) and high repetition (work cycles less than 30 sec or greater than 50% of cycle time performing same task, length of shortest task less than 10 sec).
<b>Good evidence</b>	Repetition or force independently, use of vibration hand tools.
<b>Some evidence</b>	Wrist ulnar deviation and extension
<b>Insufficient or conflicting evidence</b>	Pinch/grip, keyboarding.

E. Laboratory tests are generally accepted, well-established, and widely used procedures. Patients should be carefully screened at the initial exam for signs or symptoms of diabetes, hypothyroidism, arthritis, and related inflammatory diseases. The presence of concurrent disease does not negate work-relatedness of any specific case. When a patient's history and physical examination suggest infection, metabolic or endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders (e.g., rheumatoid arthritis), or potential problems related to prescription of medication (e.g., renal disease and nonsteroidal anti-inflammatory medications), then laboratory tests, including, but not limited to, the following can provide useful diagnostic information:

1. Serum rheumatoid factor and Antinuclear Antigen (ANA) for rheumatoid work-up;
2. Thyroid Stimulating Hormone (TSH) for hypothyroidism;
3. Fasting glucose is recommended for obese men and women over 40 years of age, patients with a history of family diabetes, those from high-risk ethnic groups, and with a previous history of impaired glucose tolerance. A fasting blood glucose greater than 125mg/dl is diagnostic for diabetes. Urine dipstick positive for glucose is a specific but not sensitive screening test. Quantitative urine glucose is sensitive and specific in high-risk populations;
4. Serum protein electrophoresis;
5. Sedimentation rate, nonspecific, but elevated in infection, neoplastic conditions and rheumatoid arthritis;
6. Serum calcium, phosphorus, uric acid, alkaline and acid phosphatase for metabolic, endocrine and neoplastic conditions;
7. Complete Blood Count (CBC), liver and kidney function profiles for metabolic or endocrine disorders or for adverse effects of various medications;
8. Bacteriological (microorganism) work-up for wound, blood and tissue;
9. Serum B6 routine screening is not recommended due to the fact that vitamin B6 supplementation has not been proven to affect the course of carpal tunnel syndrome. However, it may be appropriate for patients on medications that interfere with the effects of vitamin B6, or for those with significant nutritional problems.

a. The OWCA recommends the above diagnostic procedures be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### §2209. Follow-up diagnostic testing procedures

A. Electrodiagnostic (EDX) studies are well established and widely accepted for evaluation of patients suspected of having CTS. The results are highly sensitive and specific for the diagnosis. Studies may confirm the diagnosis or direct the examiner to alternative disorders. Studies require clinical correlation due to the occurrence of false positive and false negative results. Symptoms of CTS may occur with normal EDX studies, especially early in the clinical course. EDX findings in CTS reflect slowing of median motor and sensory conduction across the carpal tunnel region due to demyelination. Axonal loss, when present, is demonstrated by needle electromyography in median nerve-supplied thenar muscles. Findings include fibrillations, fasciculations, neurogenic recruitment and polyphasic units (reinnervation).

1. Needle electromyography of a sample of muscles innervated by the C5 to T1 spinal roots, including a thenar muscle innervated by the median nerve of the symptomatic limb, is frequently required.

2. The following EDX studies are not recommended to confirm a clinical diagnosis of CTS:

a. Low sensitivity and specificity compared to other EDX studies: multiple median F wave parameters, median motor nerve residual latency, and sympathetic skin response

b. Investigational studies: evaluation of the effect on median NCS of limb ischemia, dynamic hand exercises, and brief or sustained wrist positioning

3. To assure accurate testing, temperature should be maintained at 30-34C preferably recorded from the hand/digits. For temperature below 30C the hand should be warmed.

4. All studies must include normative values for their laboratories.

5. Positive Findings – Any of these nerve conduction study findings must be accompanied by median nerve symptoms to establish the diagnosis.

a. Slowing of median distal sensory and/or motor conduction through the carpal tunnel region

b. Electromyographic changes in the median thenar muscles in the absence of proximal abnormalities

c. Suggested guidelines for the upper limits of normal latencies:

i. Median distal motor latency (DML)-4.5msec/8cm

ii. Median distal sensory peak latency (DSL)-3.6msec/14cm

iii. Median intrapalmar peak latency (palm-wrist)-2.2msec/8cm

iv. Median-ulnar palmar sensory latency difference greater than 0.3msec

6. Because laboratories establish their own norms, a degree of variability from the suggested guideline values is acceptable.

7. In all cases, normative values are to be provided with the neurodiagnostic evaluation.

8. Suggested grading scheme by electrodiagnostic criteria for writing a consultation or report may be:

a. Mild CTS-prolonged (relative or absolute) median sensory or mixed action potential distal latency (orthodromic, antidromic, or palmar).

b. Moderate CTS-abnormal median sensory latencies as above, and prolongation (relative or absolute) of median motor distal latency.

c. Severe CTS-prolonged median motor and sensory distal latencies, with either absent or sensory or palmar potential, or low amplitude or absent thenar motor action potential. Needle examination reveals evidence of acute and chronic denervation with axonal loss.

9. Frequency of Studies/Maximum Number of Studies:

a. Indications for Initial Testing

i. patients who do not improve symptomatically or functionally with conservative measures for carpal tunnel syndrome over a three to four week period;

ii. patients in whom the diagnosis is in question;

iii. patients for whom surgery is contemplated;

iv. to rule out other nerve entrapments or a radiculopathy.

b. repeated studies may be performed:

i. to determine disease progression. 8-12 weeks is most useful when the initial studies were normal and CTS is still suspected.

ii. for inadequate improvement with non-surgical treatment for 8-12 weeks ;

iii. for persistent or recurrent symptoms following carpal tunnel release, post-op three to six months, unless an earlier evaluation is required by the surgeon.

B. Imaging Studies

1. Radiographic Imaging. Not generally required for most CTS diagnoses. However, it may be necessary to rule out other pathology in the cervical spine, shoulder, elbow, wrist or hand. Wrist and elbow radiographs would detect degenerative joint disease, particularly scapholunate dissociation and thumb carpometacarpal abnormalities which occasionally occur with CTS.

2. Magnetic Resonance Imaging (MRI). Considered experimental and not recommended for diagnosis of Carpal Tunnel Syndrome. Trained neuroradiologists have not identified a single MRI parameter that is highly sensitive and specific. MRI is less accurate than standard electrodiagnostic testing, and its use as a diagnostic tool is not recommended.

3. Sonography. This tool has not been sufficiently studied to define its diagnostic performance relative to electrodiagnostic studies. It is not a widely applied test. Sonography may detect synovial thickening in CTS caused by rheumatoid arthritis. It may be useful if space-occupying lesions, such as, lipomas, hemangiomas, fibromas, and ganglion cysts, are suspected. Its routine use in CTS is not recommended.

C. Adjunctive testing. Clinical indications for the use of tests and measurements are predicated on the history and systems review findings, signs observed on physical examination, and information derived from other sources and records. They are not designed to be the definitive indicator of dysfunction.

1. Electromyography. is a generally accepted, well-established procedure. It is indicated when acute and/or chronic neurogenic changes in the thenar eminence are associated with the conduction abnormalities discussed above.

2. Electroneurometer is not recommended as a diagnostic tool because it requires patient participation, cannot distinguish between proximal and distal lesions, and does not have well-validated reference values.

3. Portable Automated Electrodiagnostic. Device measures distal median nerve motor latency and F-wave latency at the wrist and has been tested in one research setting. It performed well in this setting following extensive calibration of the device. Motor nerve latency compared favorably with conventional electrodiagnostic testing, but F-wave latency added little to diagnostic accuracy. It remains an investigational instrument whose performance in a primary care setting is as yet not established, and is not recommended as a substitute for conventional electrodiagnostic testing in clinical decision-making.

4. Quantitative Sensory Testing (QST) may be used as a screening tool in clinical settings pre- and post-operatively. Results of tests and measurements of sensory integrity are integrated with the history and systems review findings and the results of other tests and measures. QST has been divided into two types of testing:

a. Threshold tests measure topognosis, the ability to exactly localize a cutaneous sensation, and pallesthesia, the ability to sense mechanical using vibration discrimination testing (quickly adapting fibers); Semmes-Wienstein monofilament testing (slowly adapting fibers);

b. Density Tests also measure topognosis and pallesthesia using static two-point discrimination (slowly adapting fibers); moving two-point discrimination (quickly adapting fibers).

5. Pinch and Grip Strength Measurements are Not generally accepted as a diagnostic tool for CTS. Strength is defined as the muscle force exerted by a muscle or group of muscles to overcome a resistance under a specific set of circumstances. Pain, the perception of pain secondary to abnormal sensory feedback, and/or the presence of abnormal sensory feedback affecting the sensation of the power used in grip/pinch may cause a decrease in the force exerted and thereby not be a true indicator of strength. When all five handle settings of the dynamometer are used, a bell-shaped curve, reflecting maximum strength at the most comfortable handle setting, should be present. These measures provide a method for quantifying strength that can be used to follow a patient's progress and to assess response to therapy. In the absence of a bell-shaped curve, clinical reassessment is indicated.

6. Laboratory Tests. In one study of carpal tunnel patients seen by specialists, nine percent of patients were diagnosed with diabetes, seven percent with hypothyroidism, and 15 percent with chronic inflammatory disease including spondyloarthropathy, arthritis, and systemic lupus erythematosus. Up to two thirds of the patients were not aware of their concurrent disease. Estimates of the prevalence of hypothyroidism in the general population vary widely, but data collected from the Colorado Thyroid Disease Prevalence Study revealed subclinical hypothyroidism in 8.5 percent of participants not taking thyroid medication. The prevalence of chronic joint symptoms in the Behavioral Risk Factor Surveillance System (BRFSS) from the Centers for Disease Control (CDC) was 12.3 percent. If after two to three weeks, the patient is not improving the physician should strongly consider the following laboratory studies: thyroid function studies, rheumatoid screens, chemical panels, and others, if clinically indicated. Laboratory testing may be required periodically to monitor patients on chronic medications.

D. Special tests are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, and physical work demand classifications and tolerance.

#### 1. Personality/Psychological/Psychiatric/ Psychosocial Evaluations.

a. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between

pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery;

b. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- i. employment history;
- ii. interpersonal relationships-both social and work;
- iii. patient activities;
- iv. current perception of the medical system;
- v. current perception/attitudes toward employer/job;
- vi. results of current treatment;
- vii. risk factors and psychological comorbidities that may influence outcome and that may require treatment;
- viii. childhood history, including history of childhood psychological trauma, abuse and family history of disability.

c. Personality/psychological/psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

d. Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

i. Job site evaluation is a comprehensive analysis of the physical, mental and sensory components of a specific job. These components may include, but are not limited to: postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; environmental requirements of a job; repetitiveness; and essential functions of a job. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

(a). Frequency: One time with additional visits as needed for follow-up per job site.

ii. Functional Capacity evaluation is a comprehensive or modified evaluation of the various aspects

of function as they relate to the worker's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range of motion, coordination and strength, worker habits, employability and financial status, as well as psychosocial aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; and non-material and material handling activities.

(a). Frequency: Can be used initially to determine baseline status. Additional evaluations can be performed to monitor and assess progress and aid in determining the endpoint for treatment.

iii. Vocational Assessment: The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

(a). Frequency: One time with additional visits as needed for follow-up

iv. Work Tolerance Screening: is a determination of an individual's tolerance for performing a specific job as based on a job activity or task. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. May be used when a full FCE is not indicated.

a. Frequency: One time for evaluation. May monitor improvements in strength every three to four weeks up to a total of six evaluations.

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HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2211. Therapeutic Procedures – Non-Operative**

A. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to "Return-to-Work" in this section for detailed information.

C. Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

D. Third, providers should provide and document education to the patient. No treatment plan is complete

without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

E. Lastly, formal psychological or psychosocial screening should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. In cases where a patient is unable to attend an outpatient center, home therapy may be necessary. Home therapy may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone. Home therapy is usually of short duration and continues until the patient is able to tolerate coming to an outpatient center.

G. Non-operative treatment procedures for CTS can be divided into two groups: conservative care and rehabilitation. Conservative care is treatment applied to a problem in which spontaneous improvement is expected in 90 percent of the cases within three months. It is usually provided during the tissue-healing phase and lasts no more than six months, and often considerably less. Rehabilitation is treatment applied to a more chronic and complex problem in a patient with de-conditioning and disability. It is provided during the period after tissue healing to obtain maximal medical recovery. Treatment modalities may be utilized sequentially or concomitantly depending on chronicity and complexity of the problem, and treatment plans should always be based on a diagnosis utilizing appropriate diagnostic procedures.

H. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation and there is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Definition: Acupuncture is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

- i. Time to produce effect: three to six treatments
- ii. Frequency: one to three times per week
- iii. Optimum duration: one to two months
- iv. Maximum duration: 14 treatments

b. Acupuncture with Electrical Stimulation is the use of electrical current (micro- amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

- i. Time to produce effect: three to six treatments
- ii. Frequency: one to three times per week
- iii. Optimum duration: one to two months
- iv. Maximum duration: 14 treatments

c. Other Acupuncture Modalities. Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy and Passive Therapy for a description of these adjunctive acupuncture modalities.

- i. Time to produce effect: three to six treatments
- ii. Frequency: one to three times per week
- iii. Optimum duration: one to two months
- iv. Maximum duration: 14 treatments

(a). Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

## 2. Biofeedback

a. A form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

b. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

c. Indications for biofeedback include individuals who are suffering from musculoskeletal injury where muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery.

Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized along with other treatment modalities.

- i. Time to produce effect: three to four sessions
- ii. Frequency: one to two times per week
- iii. Optimum duration: five to six sessions
- iv. Maximum duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic or functional gains.

## 3. Injections-Therapeutic.

a. Steroids Injections. Beneficial effects of injections are well-established, but generally considered to be temporary. Recurrence of symptoms is frequent. It is not clear whether or not injections slow progression of electrodiagnostic changes. Therefore, although symptoms may be temporarily improved, nerve damage may be progressing. When motor changes are present, surgery is preferred over injections. Injections may be given for confirmation of Carpal Tunnel Syndrome Diagnosis.

- i. Time to produce effect: two to five days
- ii. Frequency: every six to eight weeks
- iii. Optimum number: two injections
- iv. Maximum number: three injections in 6 months

b. If following the first injection, symptomatic relief is followed by recurrent symptoms, the decision to perform a second injection must be weighed against alternative treatments such as surgery. Surgery may give more definitive relief of symptoms.

4. Job Site Alteration. Early evaluation and training of body mechanics and other ergonomic factors are essential for every injured worker and should be done by a qualified individual. In some cases, this requires a job site evaluation. Some evidence supports alteration of the job site in the early treatment of Carpal Tunnel Syndrome (CTS). There is no single factor or combination of factors that is proven to prevent or ameliorate CTS, but a combination of ergonomic and psychosocial factors is generally considered to be important. Physical factors that may be considered include use of force, repetition, awkward positions, upper extremity vibration, cold environment, and contact pressure on the carpal tunnel. Psychosocial factors to be considered include pacing, degree of control over job duties, perception of job stress, and supervisory support. The job analysis and modification should include input from the employee, employer, and ergonomist or other professional familiar with work place evaluation. The employee must be observed performing all job functions in order for the job site analysis to be valid. Periodic follow-up is recommended to evaluate effectiveness of the intervention and need for additional ergonomic changes.

a. Ergonomic changes should be made to modify the hazards identified. In addition workers should be counseled to vary tasks throughout the day whenever possible. Occupational Safety and Health Administration (OSHA) suggests that workers who perform repetitive tasks, including keyboarding, take 15-30 second breaks every 10 to

20 minutes, or 5-minute breaks every hour. Mini breaks should include stretching exercises.

b. Interventions should consider engineering controls, e.g., mechanizing the task, changing the tool used, or adjusting the work site, or administrative controls, e.g., adjusting the time an individual performs the task.

c. Seating Description. The following description may aid in evaluating seated work positions: The head should incline only slightly forward, and if a monitor is used, there should be 18-24 inches of viewing distance with no glare. Arms should rest naturally, with forearms parallel to the floor, elbows at the sides, and wrists straight or minimally extended. The back must be properly supported by a chair, which allows change in position and backrest adjustment. There must be good knee and legroom, with the feet resting comfortably on the floor or footrest. Tools should be within easy reach, and twisting or bending should be avoided.

d. Job Hazard Checklist. The following Table 3 is adopted from Washington State's job hazard checklist, and may be used as a generally accepted guide for identifying job duties which may pose ergonomic hazards. The fact that an ergonomic hazard exists at a specific job, or is suggested in the table, does not establish a causal relationship between the job and the individual with a musculoskeletal injury. However, when an individual has a work-related injury and ergonomic hazards exist that affect the injury, appropriate job modifications should be made. Proper correction of hazards may prevent future injuries to others, as well as aid in the recovery of the injured worker.

**Table 3: Identifying Job Duties Which May Pose Ergonomic Hazards**

Type of Job Duty	Hours per Day
Pinching an unsupported object(s) weighing 2 lbs or more per hand, or pinching with a force of 4 lbs or more per hand (comparable to pinching a half a ream of paper): Highly repetitive motion Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 3 hours total/day ----- More than 4 hours total/day
Gripping an unsupported object(s) weighing 10 lbs or more/hand, or gripping with a force of 10 lbs or more/hand (comparable to clamping light duty automotive jumper cables onto a battery): *Handles should be rounded and soft, with at least 1-2.5" in diameter grips at least 5" long. Highly repetitive motion Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 3 hours total/day ----- More than 4 hours total/day
Repetitive Motion (using the same motion with little or no variation every few seconds), excluding keying activities: High, forceful exertions with the hands, with palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees ----- No other risk factors	More than 2 hours total/day ----- More than 6 hours total/day
Intensive Keying: Palmar flexion greater than 30 degrees, dorsiflexion greater than 45 degrees, or radial deviation greater than 30 degrees -----	More than 4 hours total/day ----- More than 7 hours total/day

Type of Job Duty	Hours per Day
No other risk factors	
Repeated Impact: Using the hand (heel/base of palm) as a hammer more than once/minute	More than 2 hours total/day
Vibration: Two determinants of the tolerability of segmental vibration of the hand are the frequency and the acceleration of the motion of the vibrating tool, with lower frequencies being more poorly tolerated at a given level of imposed acceleration, expressed below in multiples of the acceleration due to gravity (10m/sec/sec). Frequency range 8-15 Hz and acceleration 6 g Frequency range 80 Hz and acceleration 40 g Frequency range 250 Hz and acceleration 250 g ----- Frequency range 8-15 Hz and acceleration 1.5 g Frequency range 80 Hz and acceleration 6 g Frequency range 250 Hz and acceleration 20 g	More than 30 minutes at a time ----- More than 4 hours at a time

5. Medications including nonsteroidal anti-inflammatory medications (NSAIDs), oral steroids, diuretics, and pyridoxine (Vitamin B6) have not been shown to have significant long-term beneficial effect in treating Carpal Tunnel Syndrome. Although NSAIDs are not curative, they and other analgesics may provide symptomatic relief. All narcotics and habituating medications should be prescribed with strict time, quantity, and duration guidelines with a definite cessation parameter. Prescribing these drugs on an as needed basis (PRN) should almost always be avoided.

a. Vitamin B6: Randomized trials have demonstrated conflicting results. Higher doses may result in development of a toxic peripheral neuropathy. In the absence of definitive literature showing a beneficial effect, use of Vitamin B6 cannot be recommended.

b. Oral Steroids: have been shown to have short-term symptomatic benefit but no long-term functional benefit and are not recommended due to possible side effects.

6. Occupational Rehabilitation Programs

a. Non-Interdisciplinary. These programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to achieve treatment and/or simulated/real work.

i. Work Conditioning. These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(a). Length of visit: one to two hours per day

(b). Frequency: two to five visits per week

(c). Optimum duration: two to four weeks

(d). Maximum duration: six weeks. Participation in a program beyond six weeks must be documented with

respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and or Job site Analysis.

- (a). Length of visit: two to six hours per day
- (b). Frequency: two to five visits per week
- (c). Optimum duration: two to four weeks
- (d). Maximum duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

b. Interdisciplinary programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured workers program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. For patients with chronic pain, refer to the Chronic Pain Disorder Medical Treatment Guideline.

i. Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

ii. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation, team physicians having experience in occupational rehabilitation, occupational therapy, physical therapy, case manager, and psychologist. As appropriate, the team may also include: chiropractor, RN, or vocational specialist.

- (a). Length of visit: Up to eight hours/day
- (b). Frequency: two to five visits per week
- (c). Optimum duration: two to four weeks
- (d). Maximum duration: six weeks. Participation

in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

7. Orthotics/Immobilization with Splinting is a generally accepted, well-established and widely used therapeutic procedure. There is some evidence that splinting leads to more improvement in symptoms and hand function than watchful waiting alone. Because of limited patient compliance with day and night splinting in published studies, evidence of effectiveness is limited to nocturnal

splinting alone. Splints should be loose and soft enough to maintain comfort while supporting the wrist in a relatively neutral position. This can be accomplished using a soft or rigid splint with a metal or plastic support. Splint comfort is critical and may affect compliance. Although off-the-shelf splints are usually sufficient, custom thermoplastic splints may provide better fit for certain patients.

a. Splints may be effective when worn at night or during portions of the day, depending on activities. Most studies show that full time night splinting for a total of four to six weeks is the most effective protocol. Depending on job activities, intermittent daytime splinting can also be helpful. Splint use is rarely mandatory. Providers should be aware that over-usage is counterproductive, and should counsel patients to minimize daytime splint use in order avoid detrimental effects such as stiffness and dependency over time.

b. Splinting is generally effective for milder cases of CTS. Long-term benefit has not been established. An effect should be seen in two-four weeks.

i. Time to produce effect: one-four weeks. If, after four weeks, the patient has partial improvement, continue to follow since neuropathy may worsen, even in the face of diminished symptoms.

ii. Frequency: Nightly. Daytime intermittent, depending on symptoms and activities

iii. Optimum duration: four to eight weeks

iv. Maximum duration: two to four months. If symptoms persist, consideration should be given to either repeating electrodiagnostic studies or to more aggressive treatment.

#### 8. Patient Education

a. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed.

i. Time to produce effect: Varies with individual patient

ii. Frequency: Should occur at every visit

#### 9. Personality/Psychological/Psychiatric/

Psychosocial Intervention is generally accepted, widely used and well established. This group of therapeutic and diagnostic modalities includes, but is not limited to, individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis and meditation. Any screening or diagnostic workup should clarify and distinguish between preexisting versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. This can be used alone or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the Chronic Pain Disorder Medical Treatment Guidelines.

a. Time to produce effect: two to four weeks

b. Frequency: one to three times weekly for the first 4 weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly.

c. Optimum duration: six weeks to three months

d. Maximum duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required and if further counseling beyond 3 months is indicated, documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every 4 to 6 weeks during treatment.

10. Restriction of Activities. Continuation of normal daily activities is the recommendation for acute and chronic pain without neurologic symptoms. There is good evidence against the use of bed rest in cases without neurologic symptoms. Bed rest may lead to de-conditioning and impair rehabilitation. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with Carpal Tunnel Syndrome

a. Medication use in the treatment of Carpal Tunnel Syndrome is appropriate for controlling acute and chronic pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to post-surgical healing. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated periodically.

11. Return to Work. Early return-to-work should be a prime goal in treating Carpal Tunnel Syndrome given the poor prognosis for the injured employee who is out of work for more than six months. The employee and employer should be educated in the benefits of early return-to-work. When attempting to return an employee with CTS to the workplace, clear, objective physical restrictions that apply to both work and non-work related activities should be specified by the provider. Good communication between the provider, employee, and employer is essential. Return-to-work is any work or duty that the employee can safely perform, which may not be the worker's regular job activities. Due to the large variety of jobs and the spectrum of severity of CTS, it is not possible for the OWCA to make specific return-to-work guidelines, but the following general approach is recommended:

a. Establishment of Return-To-Work. Ascertainment of return-to-work status is part of the medical treatment and rehabilitation plan, and should be addressed at every visit. Limitations in ADLs should also be reviewed at every encounter, and help to provide the basis for work restrictions provided they are consistent with objective findings. The OWCA recognizes that employers vary in their ability to accommodate restricted duty, but encourages employers to be active participants and advocates for early return-to-work. In most cases, the patient can be returned to work in some capacity, either at a modified job or alternate position, immediately unless there are extenuating circumstances, which should be thoroughly documented and communicated

to the employer. Return-to-work status should be periodically reevaluated, at intervals generally not to exceed three weeks, and should show steady progression towards full activities and full duty.

b. Establishment of Activity Level Restrictions: It is the responsibility of the physician/provider to provide both the employee and employer clear, concise, and specific restrictions that apply to both work and non-work related activities. The employer is responsible to determine whether modified duty can be provided within the medically determined restrictions. Refer to the "Job Site Alteration" section for specific activity and ergonomic factors to be considered when establishing work restrictions for an employee with CTS.

c. Compliance with Activity Level Restrictions: The employee's compliance with the activity level restrictions is an important part of the treatment plan and should be reviewed at each visit. In some cases, a job site analysis, a functional capacity evaluation, or other special testing may be required to facilitate return-to-work and document compliance. Refer to the "Job Site Alteration" and "Work Tolerance Screening" sections.

## 12. Therapy - Active.

a. Active therapies are based on the philosophy that therapeutic exercises and/or activities are beneficial for restoring flexibility, strength, endurance, function, range of motion, and alleviating discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task, and thus assists in developing skills promoting independence to allow self-care to continue after discharge. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instructions(s). At times a provider may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient.

b. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistance devices.

c. Interventions are selected based on the complexity of the presenting dysfunction with ongoing examination, evaluation and modification of the plan of care as improvement or lack thereof occurs. Change and/or discontinuation of an intervention should occur if there is attainment of expected goals/outcome, lack of progress, lack of tolerance and/or lack of motivation. Passive interventions/modalities may only be used as adjuncts to the active program.

i. Nerve Gliding exercises consist of a series of flexion and extension movements of the hand and wrist that produce tension and longitudinal movement along the length of the median and other nerves of the upper extremity. These exercises are based on the principle that the tissues of the peripheral nervous system are designed for movement, and that tension and glide (excursion) of nerves may have an effect on neurophysiology through alterations in vascular and axoplasmic flow. Biomechanical principles have been more thoroughly studied than clinical outcomes. Randomized trials have been lacking or have suffered from design flaws that preclude sound conclusions of the

effectiveness of these exercises, but these flaws have tended to underestimate rather than overestimate the usefulness of nerve gliding. The exercises are simple to perform and can be done by the patient after brief instruction. It is considered accepted therapy for CTS.

- (a). Time to Produce Effect: two-four weeks
  - (b). Frequency: Up to five times per day by patient (patient-initiated)
  - (c). Optimum Duration: two sessions
  - (d). Maximum Duration: three sessions
- ii. Instruction in Therapeutic Exercise. Instruction should focus on alleviating associated myofascial symptoms. Please refer to the Cumulative Trauma Disorder (CTD) guideline for information on therapeutic exercise techniques.
  - iii. Proper Work Techniques. Please refer to the "Job Site Evaluation" and "Job Site Alteration" sections of this guideline.

13. Therapy-Passive. Therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used in adjunct with active therapies. They may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment. Diathermies have not been shown to be beneficial to patients with CTS and may interfere with nerve conduction.

a. Manual Therapy Techniques are passive interventions in which the providers use his or her hands to administer skilled movements designed to modulate pain; increase joint range of motion; reduce/eliminate soft tissue swelling, inflammation, or restriction; induce relaxation; and improve contractile and non-contractile tissue extensibility. These techniques are applied only after a thorough examination is performed to identify those for whom manual therapy would be contraindicated or for whom manual therapy must be applied with caution. Soft tissue mobilization/manipulation techniques are generally accepted and widely used adjunctive treatment modalities in the treatment of myofascial symptoms related to carpal tunnel syndrome. Mobilization and manipulation can include myofascial release therapy, muscle energy techniques, neural gliding, high velocity, low amplitude (HVLA) technique, osteopathic manipulation, joint mobilization and non-force techniques.

- i. Time to produce effect: two-six treatments
  - ii. Frequency: one-three times/week, decreasing over time
  - iii. Optimum duration: four-six weeks
  - d. Maximum duration: eight-ten weeks
- b. Ultrasound: There is some evidence that ultrasound may be effective in symptom relief and in improving nerve conduction in mild to moderate cases of CTS. No studies have demonstrated long-term functional benefit. It may be used in conjunction with an active therapy program for non-surgical patients who do not improve with splinting and activity modification. It is not known if there are any long-term deleterious neurological effects from ultrasound.

c. Microcurrent TENS: There is some evidence that concurrent application of microamperage TENS applied to distinct acupuncture points and low-level laser treatment may be useful in treatment of mild to moderate CTS. This treatment may be useful for patients not responding to initial conservative treatment or who wish to avoid surgery. Patient selection criteria should include absence of denervation on EMG and motor latencies not exceeding 7 ms. The effects of microamperage TENS and low-level laser have not been differentiated; there is no evidence to suggest whether only one component is effective or the combination of both is required.

- i. Time to produce effect: one week
- ii. Frequency: three sessions per week
- iii. Optimum duration: three weeks
- iv. Maximum duration: four weeks
- v. Other Passive Therapy: For associated myofascial symptoms, please refer to the Cumulative Trauma Disorder guideline.

14. Vocational Rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification highest functional level, motivation, and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression and promote optimum rehabilitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2213. Therapeutic Procedures - Operative**

A. Surgical Decompression is well-established, generally accepted, and widely used and includes open and endoscopic techniques. There is good evidence that surgery is more effective than splinting in producing long-term symptom relief and normalization of median nerve conduction velocity.

1. Endoscopic Techniques have had a higher incidence of serious complications (up to 5%) compared to open techniques (less than 1%). The most commonly seen serious complications are incomplete transection of the transverse carpal ligament and inadvertent nerve or vessel injuries. The incidence of complications may be lower for surgeons who have extensive experience and familiarity with certain endoscopic techniques. Choice of technique should be left to the discretion of the surgeon.

2. Indications for Surgery include positive history, abnormal electrodiagnostic studies, and/or failure of conservative management. Job modification should be considered prior to surgery. Please refer to the "Job Site Alteration" section for additional information on job modification.

3. Surgery as an Initial Therapy. Surgery should be considered as an initial therapy in situations where:

- a. Median nerve trauma has occurred; "acute carpal tunnel syndrome", or

b. Electrodiagnostic evidence of moderate to severe neuropathy. EMG findings showing evidence of acute or chronic motor denervation suggest the possibility that irreversible damage may be occurring.

4. Surgery When Electrodiagnostic Testing is Normal. Surgery may be considered in cases where electrodiagnostic testing is normal. A second opinion from a hand surgeon is strongly recommended. The following criteria should be considered in deciding whether to proceed with surgery.

a. the patient experiences significant temporary relief following steroid injection into the carpal tunnel; or

b. the patient has failed 3-6 months of conservative treatment including work site change; and

c. psychosocial factors have been addressed through psychological screening requirements as defined "Adjunctive Testing" in this Section; and

d. the patient's signs and symptoms are specific for carpal tunnel syndrome

5. Suggested parameters for return-to-work are:

Time Frame	Activity Level
2 Days	Return to Work with Restrictions on utilizing the affected extremity
2-3 Weeks	Sedentary and non-repetitive work
4-6 Weeks	Case-by-case basis
6-12 Weeks	Heavy Labor, forceful and repetitive

NOTE: All return-to-work decisions are based upon clinical outcome.

B. Neurolysis has not been proven advantageous for carpal tunnel syndrome. Internal neurolysis should never be done. Very few indications exist for external neurolysis.

C. Tenosynovectomy has not proven to be of benefit in carpal tunnel syndrome.

D. Consideration For Repeat Surgery.

1. The single most important factor in predicting symptomatic improvement following carpal tunnel release is the severity of preoperative neuropathy. Patients with moderate electrodiagnostic abnormalities have better results than those with either very severe or no abnormalities. Incomplete cutting of the transverse carpal ligament or iatrogenic injury to the median nerve are rare. If median nerve symptoms do not improve following initial surgery or symptoms improve initially and then recur, but are unresponsive to non-operative therapy (see Therapeutic Procedures, Non-Operative) consider the following:

a. Recurrent synovitis;

b. Repetitive work activities may be causing "dynamic" CTS;

c. Scarring;

d. Work-up of systemic diseases

2. A second opinion by a hand surgeon is required if repeat surgery is contemplated. The decision to undertake repeat surgery must factor in all of the above possibilities. Results of surgery for recurrent carpal tunnel syndrome vary widely depending on the etiology of recurrent symptoms.

E. Post-Operative Treatment.

1. Considerations for post-operative therapy are:

a. Immobilization: There is some evidence showing that immediate mobilization of the wrist following surgery is associated with less scar pain and faster return to work. Final decisions regarding the need for splinting post-operatively should be left to the discretion of the treating physician

based upon his/her understanding of the surgical technique used and the specific conditions of the patient.

b. Home Program: It is generally accepted that all patients should receive a home therapy protocol involving stretching, ROM, scar care, and resistive exercises. Patients should be encouraged to use the hand as much as possible for daily activities, allowing pain to guide their activities.

c. Supervised Therapy Program: may be helpful in patients who do not show functional improvements post-operatively or in patients with heavy or repetitive job activities. The therapy program may include some of the generally accepted elements of soft tissue healing and return to function:

i. Soft tissue healing/remodeling: May be used after the incision has healed. It may include all of the following: evaluation, whirlpool, electrical stimulation, soft tissue mobilization, scar compression pad, heat/cold application, splinting or edema control may be used as indicated. Following wound healing, ultrasound and iontophoresis with Sodium Chloride (NaCl) may be considered for soft tissue remodeling. Diathermy is a non-acceptable adjunct.

ii. Return to function: Range of motion, therapeutic exercises and stretching exercises, strengthening, activity of daily living adaptations, joint protection instruction, posture/body mechanics education; worksite modifications may be indicated.

(a). Time to produce effect: two-four weeks

(b). Frequency: two-three times/week

(c). Optimum duration: four-six weeks

(d). Maximum duration: eight weeks

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2214. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:

OWCA—Medical Services

ATTN: Medical Director

P.O. Box 94040

Baton Rouge, LA 70804

1. Social Security No. \_ \_ - \_ - \_

2. Date of Injury/Illness \_ - \_ - \_

3. Parts of Body Injury \_\_\_\_\_

4. Date of Birth \_ - \_ - \_

5. Date of This Request \_ - \_ - \_

6. Claim Number \_\_\_\_\_

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by  
 \_\_\_ Employee \_\_\_ Employer \_\_\_ Insurer \_\_\_ Health Care Provider \_\_\_  
 Other \_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.



6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-evaluation treatment every three to four weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return-to-Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines

outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. "Consensus" means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. "Some" means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. "Good" means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. "Strong" means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2305. Initial diagnostic procedures**

A. The OWCA recommends the following diagnostic procedures be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Standard procedures that should be utilized when initially diagnosing a work-related lower extremity complaint are listed below.

1. History-taking and physical examination (Hx & PE) are generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictates subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not complementing each other, the objective clinical findings should have preference. The medical records should reasonably document the following:

a. History of Present Injury

i. Mechanism of injury. This includes details of symptom onset and progression. It should include such details as: the activity at the time of the injury, patient description of the incident, and immediate and delayed

symptoms. The history should elicit as much detail about these mechanisms as possible.

ii. Relationship to work. This includes a statement of the probability that the illness or injury is work-related.

iii. History of locking, clicking, popping, giving way, acute or chronic swelling, crepitation, pain while ascending or descending stairs (e.g. handrail used, 'foot by foot' instead of 'foot over foot') inability to weight bear due to pain, intolerance for standing or difficulty walking distances on varied surfaces, difficulty crouching or stooping, and wear patterns on footwear. Patients may also report instability or mechanical symptoms.

iv. Any history of pain in back as well as joints distal and proximal to the site of injury. The use of a patient completed pain drawing, Visual Analog Scale (VAS), is highly recommended, especially during the first two weeks following injury to assure that all work related symptoms are addressed.

v. Ability to perform job duties and activities of daily living; and

vi. Exacerbating and alleviating factors of the reported symptoms. The physician should explore and report on non-work related as well as, work related activities.

vii. Prior occupational and non-occupational injuries to the same area including specific prior treatment and any prior bracing devices.

viii. Discussion of any symptoms present in the uninjured extremity.

ix. Lower extremity injuries are frequently not isolated, but are accompanied by other injuries. In the setting of a traumatic brain injury (TBI), long bone fracture management must consider the effect of TBI on bone metabolism and may require more aggressive treatment. Refer to the Traumatic Brain Injury Medical Treatment Guidelines, Musculoskeletal Complications.

#### b. Past History

i. past medical history includes neoplasm, gout, arthritis, previous musculoskeletal injuries, and diabetes;

ii. review of systems includes symptoms of rheumatologic, neurological, endocrine, neoplastic, and other systemic diseases;

iii. History of smoking, alcohol use, and substance abuse;

iv. History of corticosteroid use; and

v. vocational and recreational pursuits.

c. Physical Examination: Examination of a joint should begin with examination of the uninjured limb and include assessment of the joint above and below the affected area of the injured limb. Physical examinations should include accepted tests as described in textbooks or other references and exam techniques applicable to the joint or region of the body being examined, including:

i. Visual inspection; Swelling: may indicate joint effusion from trauma, infection or arthritis. Swelling or bruising over ligaments or bones can indicate possible fractures or ligament damage;

ii. Palpation: for joint line tenderness, effusion, and bone or ligament pain. Palpation may be used to assess tissue tone and contour; myofascial trigger points; and may be graded for intensity of pain. Palpation may be further divided into static and motion palpation. Static palpation consists of feeling bony landmarks and soft tissue structures

and consistency. Motion palpation is commonly used to assess joint movement patterns and identify joint dysfunction;

iii. Assessment of activities of daily living including gait abnormalities, especially after ambulating a distance and difficulties ascending/descending stairs; Assessment of activities such as the inability to crouch or stoop, may give important indications of the patient's pathology and restrictions;

iv. range-of-motion/quality-of-motion; should be assessed actively and passively;

v. strength;

vi. joint stability;

vii. Hip exam: In general multiple tests are needed to reliably establish a clinical diagnosis. Spinal pathology and groin problems should always be considered and ruled out as a cause of pain for patients with hip symptomatology. The following is a list of commonly performed tests;

(a). Flexion-Abduction-External Rotation (FABER-aka Patrick's) test - is frequently used as a test for sacral pathology;

(b). Log roll test - may be used to assess iliofemoral joint laxity;

(c). Ober's is used to test the iliotibial band;

(d). Greater trochanter bursitis is aggravated by external rotation and adduction and resisted hip abduction or external rotation;

(e). Iliopsoas bursitis may be aggravated by stretching the tendon in hip extension;

(f). Internal and external rotation is usually painful in osteoarthritis;

(g). The maneuvers of flexion, adduction and internal rotation (FADIR) will generally reproduce pain in cases of labral tears and with piriformis strain/irritation.

viii. Knee exam: In general multiple tests are needed to reliably establish a clinical diagnosis. The expertise of the physician performing the exam influences the predictability of the exam findings. Providers should be aware that patients with osteoarthritis may have positive pain complaints with various maneuvers based on their osteoarthritis rather than ligamentous or meniscal damage. The following is a partial list of commonly performed tests.

(a). Bilateral thigh circumference measurement: assesses for quadriceps wasting which may occur soon after a knee injury. The circumferences of both thighs should be documented approximately 15 cm above a reference point, either the joint line or patella.

(b). Anterior Cruciate Ligament tests:

(i). Lachman's test;

(ii). Anterior drawer test;

(iii). Lateral pivot shift test.

(c). Meniscus tests. Joint line tenderness and effusions are common with acute meniscal tears. Degenerative meniscal tears are fairly common in older patients with degenerative changes and may be asymptomatic.

(i). McMurray test;

(ii). Apley compression test;

(iii). Medial lateral grind test;

(iv). Weight-bearing tests - include Thessaly and Ege's test.

(d). Posterior Cruciate Ligament tests:

- (i). Posterior drawer test;
- (ii). Extension lag may also be measured passively by documenting the heel height difference with the patient prone.

(e). Collateral Ligaments tests:

(i). Medial stress test – A positive test in full extension may include both medial collateral ligament and cruciate ligament pathology;

(ii). Lateral stress test.

(f). Patellar Instability tests:

(i). Apprehension test;

(ii). J sign;

(iii). Q angle.

ix. Foot and ankle exam: In general multiple tests are needed to reliably establish a clinical diagnosis. The expertise of the physician performing the exam influences the predictability of the exam findings. Ankle assessments may include anterior drawer exam, talar tilt test, external rotation stress test, ankle ligament stress test and the tibia-fibula squeeze test. Achilles tendon may be assessed with the Thompson's test. Foot examinations may include, assessment of or for: subtalar, midtarsal, and metatarsal-phalangeal joints; tarsal tunnel; and posterior tibial tendon; Morton's neuroma; the piano key test and Lisfranc injury.

x. If applicable, full neurological exam including muscle atrophy and gait abnormality.

xi. If applicable to injury, integrity of distal circulation, sensory, and motor function.

2. Radiographic imaging of the lower extremities is a generally accepted, well-established and widely used diagnostic procedure when specific indications based on history and/or physical examination are present. It should not be routinely performed. The mechanism of injury and specific indications for the radiograph should be listed on the request form to aid the radiologist and x-ray technician. For additional specific clinical indications, refer to "Specific Lower Extremity Injury Diagnosis, Testing and Treatment." Indications for initial imaging include any of the following:

a. The inability to flex knee to 90 degrees or to transfer weight for four steps at the time of the immediate injury and at the initial visit, regardless of limping;

b. Bony tenderness on any of the following areas: over the head of the fibula; isolated to the patella; of the lateral or medial malleolus from the tip to the distal 6 cm; at the base of the 5th metatarsal; or at the navicular;

c. History of significant trauma, especially blunt trauma or fall from a height;

d. Age over 55 years;

e. History or exam suggestive of intravenous drug abuse or osteomyelitis;

f. Pain with swelling and/or range of motion (ROM) limitation localizing to an area of prior fracture, internal fixation, or joint prosthesis; or

g. Unexplained or persistent lower extremity pain over two weeks.

i. Occult fractures, especially stress fractures, may not be visible on initial x-ray. A follow-up radiograph, MRI and/or bone scan may be required to make the diagnosis.

ii. Weight-bearing radiographs are used to assess osteoarthritis and alignment prior to some surgical procedures.

3. Laboratory testing. Laboratory tests are generally accepted, well-established and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, connective tissue disorder, or underlying arthritis or rheumatologic disorder based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. The OWCA recommends that lab diagnostic procedures be initially considered the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Tests include, but are not limited to:

a. Complete blood count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;

b. Erythrocyte sedimentation rate, rheumatoid factor, antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP) can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder;

c. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease;

d. Liver and kidney function may be performed for prolonged anti-inflammatory use or other medications requiring monitoring; and

e. Analysis of joint aspiration for bacteria, white cell count, red cell count, fat globules, crystalline birefringence and chemistry to evaluate joint effusion.

4. Other procedures

a. Joint Aspiration is a generally accepted, well-established and widely used procedure when specifically indicated and performed by individuals properly trained in these techniques. This is true at the initial evaluation when history and/or physical examination are of concern for a septic joint or bursitis and for some acute injuries. Particularly at the knee, aspiration of a large effusion can help to decrease pain and speed functional recovery. Persistent or unexplained effusions may be examined for evidence of infection, rheumatologic, or inflammatory processes. The presence of fat globules in the effusion strongly suggests occult fracture.

i. Risk factors for septic arthritis include joint surgery, knee arthritis, joint replacement, skin infection, diabetes, age greater than 80, immunocompromised states, and rheumatoid arthritis. More than 50 percent of patients with septic joints have a fever greater than 37.5 degrees centigrade and joint swelling. Synovial white counts of greater than 25,000 and polymorphonuclear cells of at least 90 percent increase the likelihood of a septic joint.

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**§2307. Follow-up diagnostic imaging and testing procedures**

A. One diagnostic imaging procedure may provide the same or distinctive information as obtained by other procedures. Therefore, prudent choice of procedure(s) for a single diagnostic procedure, a complementary procedure in combination with other procedures(s), or a proper sequential order in multiple procedures will ensure maximum

diagnostic accuracy; minimize adverse effect to patients and cost effectiveness by avoiding duplication or redundancy.

B. All diagnostic imaging procedures have a significant percentage of specificity and sensitivity for various diagnoses. None is specifically characteristic of a certain diagnosis. Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results.

C. When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging studies. When indicated, the following additional imaging studies can be utilized for further evaluation of the lower extremity, based upon the mechanism of injury, symptoms, and patient history. For specific clinical indications, see Section E, Specific Lower Extremity Injury Diagnosis, Testing, and Treatment. The studies below are listed in frequency of use, not importance.

a. Magnetic Resonance Imaging (MRI) are generally accepted, well-established, and widely used diagnostic procedures. It provides a more definitive visualization of soft tissue structures, including ligaments, tendons, joint capsule, menisci and joint cartilage structures, than x-ray or Computed Axial Tomography in the evaluation of traumatic or degenerative injuries. The addition of intravenous or intra-articular contrast can enhance definition of selected pathologies.

i. The high field, closed MRI with 1.5 or higher tesla provides better resolution. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique or with a reading by a musculoskeletal radiologist. All questions in this regard should be discussed with the MRI center and/or radiologist.

ii. MRIs have high sensitivity and specificity for meniscal tears and ligamentous injuries although in some cases when physical exam findings and functional deficits indicate the need for surgery an MRI may not be necessary. MRI is less accurate for articular cartilage defects (sensitivity 76 percent) than for meniscal and ligamentous injury (sensitivity greater than 90 percent).

iii. MRIs have not been shown to be reliable for diagnosing symptomatic hip bursitis.

b. MR Arthrography (MRA): This accepted investigation uses the paramagnetic properties of gadolinium to shorten T1 relaxation times and provide a more intense MRI signal. It should be used to diagnose hip labral tears. Pelvic MRIs are not sufficient for this purpose. Arthrograms are also useful to evaluate mechanical pathology in knees with prior injuries and/or surgery.

c. Computed Axial Tomography (CT) is generally accepted and provides excellent visualization of bone. It is used to further evaluate bony masses and suspected fractures

not clearly identified on radiographic window evaluation. Instrument scatter-reduction software provides better resolution when metallic artifact is of concern.

d. Diagnostic Sonography is an accepted diagnostic procedure. The performance of sonography is operator-dependent, and is best when done by a specialist in musculoskeletal radiology. It may also be useful for post-operative pain after total knee arthroplasty (TKA), and for dynamic testing especially of the foot or ankle.

e. Lineal Tomography is infrequently used, yet may be helpful in the evaluation of joint surfaces and bone healing.

f. Bone Scan (Radioisotope Bone Scanning) is generally accepted, well-established and widely used. <sup>99m</sup>TcTechnecium diphosphonate uptake reflects osteoblastic activity and may be useful in metastatic/primary bone tumors, stress fractures, osteomyelitis, and inflammatory lesions, but cannot distinguish between these entities.

i. Bone scanning is more sensitive but less specific than MRI. It is useful for the investigation of trauma, infection, stress fracture, occult fracture, Charcot joint, Complex Regional Pain Syndrome and suspected neoplastic conditions of the lower extremity.

g. Other Radionuclide Scanning: Indium and gallium scans are generally accepted, well-established, and widely used procedures usually to help diagnose lesions seen on other diagnostic imaging studies. <sup>67</sup>Gallium citrate scans are used to localize tumor, infection, and abscesses. <sup>111</sup>Indium-labeled leukocyte scanning is utilized for localization of infection or inflammation.

h. Arthrogram is an accepted diagnostic procedure. It may be useful in the evaluation of internal derangement of a joint, including when MRI or other tests are contraindicated or not available. Potential complications of this more invasive technique include pain, infection, and allergic reaction. Arthrography gains additional sensitivity when combined with CT in the evaluation of internal derangement, loose bodies, and articular cartilage surface lesions. Diagnostic arthroscopy should be considered before arthrogram when there are strong clinical indications.

2. Other diagnostic tests. The following diagnostic procedures listed in this subsection are listed in alphabetical order.

a. Compartment Pressure Testing and Measurement Devices: such as pressure manometer, are useful in the evaluation of patients who present symptoms consistent with a compartment syndrome.

b. Diagnostic Arthroscopy (DA) allows direct visualization of the interior of a joint, enabling the diagnosis of conditions when other diagnostic tests have failed to reveal an accurate diagnosis; however, it should generally not be employed for exploration purposes only. In order to perform a diagnostic arthroscopy, the patient must have completed at least some conservative therapy without sufficient functional recovery per Section E, Specific Lower Extremity Injury Diagnosis, Testing, and Treatment, and meet criteria for arthroscopic repair.

i. DA may also be employed in the treatment of acute joint disorders. In some cases, the mechanism of injury and physical examination findings will strongly suggest the presence of a surgical lesion. In those cases, it is appropriate to proceed directly with the interventional arthroscopy.

c. Doppler Ultrasonography/Plethysmography is useful in establishing the diagnosis of arterial and venous disease in the lower extremity and should usually be considered prior to the more invasive venogram or arteriogram study. Doppler is less sensitive in detecting deep vein thrombosis in the calf muscle area. If the test is initially negative and symptoms continue, an ultrasound should usually be repeated seven days later to rule out popliteal thrombosis. It is also useful for the diagnosis of popliteal mass when MRI is not available or contraindicated.

d. Electrodiagnostic Testing. Electrodiagnostic tests include, but are not limited to Electromyography (EMG), Nerve Conduction Studies (NCS) and Somatosensory Evoked Potentials (SSEP). These are generally accepted, well-established and widely used diagnostic procedures. The SSEP study, although generally accepted, has limited use. Electrodiagnostic studies may be useful in the evaluation of patients with suspected involvement of the neuromuscular system, including disorder of the anterior horn cell, radiculopathies, peripheral nerve entrapments, peripheral neuropathies, neuromuscular junction and primary muscle disease.

i. In general, these diagnostic procedures are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electrodiagnostic studies may provide useful, correlative neuropathophysiological information that would be otherwise unobtainable from standard radiologic studies.

e. Personality/Psychological/Psychiatric/Psychosocial Evaluations. These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery.

i. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- (a). employment history;
- (b). interpersonal relationships-both social and work;
- (c). patient activities;

- (d). current perception of the medical system;
- (e). current perception/attitudes toward employer/job;
- (f). results of current treatment;
- (g). risk factors and psychological comorbidities that may influence outcome and that may require treatment.
- (h). Childhood history, including history of childhood psychological trauma, abuse and family history of disability.

ii. Personality/psychological/psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

(a). Frequency. one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

f. Venogram/Arteriogram is useful for investigation of vascular injuries or disease, including deep venous thrombosis. Potential complications may include pain, allergic reaction, and deep vein thrombosis.

3. Special tests are generally well-accepted tests and are performed as part of a skilled assessment of the patient's capacity to return-to-work, his/her strength capacities, and physical work demand classifications and tolerances. The procedures in this subsection are listed in alphabetical order.

a. Computer-Enhanced Evaluations may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range of motion, balance, endurance or strength. Values obtained can include degrees of motion, torque forces, pressures or resistance. Indications include determining validity of effort, effectiveness of treatment and demonstrated motivation. These evaluations should not be used alone to determine return-to-work restrictions.

i. Frequency: One time for evaluation. Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. Functional Capacity Evaluation (FCE) is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return-to-work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range of motion, coordination and strength, worker habits, employability, as well as psychosocial aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain

assessment/psychological screening; and non-material and material handling activities.

i. When an FCE is being used to determine return to a specific jobsite, the provider is responsible for fully understanding the job duties. A jobsite evaluation is frequently necessary. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering. Full FCEs are sometimes necessary. In many cases, a work tolerance screening will identify the ability to perform the necessary job tasks. FCEs are not necessary to assign permanent impairment ratings in the Colorado workers' compensation system. If Partial FCEs are performed, it is recognized that all parts of the FCE that are not performed are considered normal.

(a). Frequency: Can be used initially to determine baseline status; and for case closure when patient is unable to return to pre-injury position and further information is desired to determine permanent work restrictions. Prior authorization is required for FCEs performed during treatment.

c. Jobsite Evaluation is a comprehensive analysis of the physical, mental and sensory components of a specific job. These components may include, but are not limited to: postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; sensation; coordination; environmental requirements of a job; repetitiveness; and essential job functions including job licensing requirements. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

i. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work.

(a). Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following:

(i). To determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

(ii). To make recommendations for, and to assess the potential for ergonomic changes;

(iii). To provide a detailed description of the physical and cognitive job requirements;

(iv). To assist the patient in their return to work by educating them on how they may be able to do their job more safely in a bio-mechanically appropriate manner; and/or

(v). To give detailed work/activity restrictions.

[a]. Frequency: One time with additional visits as needed for follow-up visits per jobsite.

d. Vocational Assessment: The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to

be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

i. Frequency: One time with additional visits as needed for follow-up

e. Work Tolerance Screening (Fitness for Duty) is a determination of an individual's tolerance for performing a specific job based on a job activity or task. It may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential. May be used when a full FCE is not indicated.

i. Frequency: One time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

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### **§2309. Specific lower extremity injury diagnosis, testing, and treatment**

#### **1. Foot and ankle**

a. Achilles Tendonopathy/or Injury and Rupture (ALTERNATE SPELLING: "TENDINOPATHY"):

i. Description/Definition: Rupture or tear of Achilles tendon or insertional or non-insertional tendonopathy.

ii. Occupational Relationship: Tears or ruptures are related to a fall, twisting, jumping, or sudden load on ankle with dorsiflexion. Tendonopathy may be exacerbated by continually walking on hard surfaces.

iii. Specific Physical Exam Findings: Swelling and pain at tendon, sometimes accompanied by crepitus and pain with passive motion. Rupture or partial tear may present with palpable deficit in tendon. If there is a full tear, Thompson test will usually be positive. A positive Thompson's test is lack of plantar flexion with compression of the calf when the patient is prone with the knee flexed.

iv. Diagnostic Testing Procedures: Radiography may be performed to identify Haglund's deformity; however, many Haglund's deformities are asymptomatic. MRI or ultrasound may be performed if surgery is being considered for tendonopathy or rupture.

#### **v. Non-operative Treatment Procedures:**

(a). Initial Treatment: Cast in non weight-bearing for tears. Protected weight-bearing for other injuries.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. Eccentric training alone or with specific bracing may be used for tendonopathy. Manual therapy may also be used. Therapy will usually include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies

include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Steroid injections should generally be avoided in these patients since this is a risk for later rupture.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Total or partial rupture.

(a). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Repair of tendons open or percutaneously with or without anchors may be required. Tendon grafts are used for chronic cases or primary surgery failures when tendon tissue is poor.

viii. Post-operative Treatment:

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Section F, Therapeutic Procedures, Non-operative.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(c). Range of motion may begin at three weeks depending on wound healing. Therapy and some restrictions will usually continue for six to eight weeks.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

b. Aggravated Osteoarthritis:

i. Description/Definition: Internal joint pathology of ankle.

ii. Occupational Relationship: The provider must establish the occupational relationship by establishing a change in the patient's baseline condition and a relationship to work activities, for example frequent jumping, climbing, or squatting.

(a). Other causative factors to consider: Prior significant injury to the ankle may predispose the joint to osteoarthritis. In order to entertain previous trauma as a cause, the patient should have a medically documented injury with radiographs or MRI showing the level of anatomic change. The prior injury should have been at least two years from the presentation for the new complaints and there should be a significant increase of pathology on the affected side in comparison to the original imaging or operative reports and/or the opposite un-injured extremity.

iii. Specific Physical Exam Findings: Pain within joint, swelling. Crepitus, locking of the joint, reduced range of motion, pain with stress tests, angular deformities.

iv. Diagnostic Testing Procedures: X-ray – mechanical axis views, CT, MRI, diagnostic injection.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: May include orthoses, custom shoes with rocker bottom shoe inserts, and braces. Cane may also be useful.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Section F., Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and range of motion. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). The patient is a good surgical candidate and pain continues to interfere with ADLs after non-surgical interventions including weight control, therapy with active patient participation, and medication.

(b). Refer to Therapeutic Procedures-Operative, for specific indications for osteotomy, ankle fusion or arthroplasty.

(c). Implants are less successful than similar procedures in the knee or hip. There are no quality studies

comparing arthrodesis and ankle replacement. Patients with ankle fusions generally have good return to function and fewer complications than those with joint replacements. Salvage procedures for ankle replacement include revision with stemmed implant or allograft fusion. Given these factors, an ankle arthroplasty requires prior authorization and a second opinion by a surgeon specializing in lower extremity surgery.

(d). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(e). In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

(f). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Arthroscopy, ankle arthroplasty or fusion. Supramalleolar osteotomies can be considered for patients with deformities or pre-existing hind foot varus or valgus deformities.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Section F, Therapeutic Procedures, Non-operative.

(b). In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(c). Treatment may include the following: restricted weight-bearing, bracing, gait training and other active therapy with or without passive therapy.

(d). Refer to Ankle Fusion, Osteotomy, or Arthroplasty for further specific information.

(e). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

c. Ankle or Subtalar Joint Dislocation:

i. Description/Definition: Dislocation of ankle or subtalar joint.

ii. Occupational Relationship: Usually occurs with falling or twisting.

iii. Specific Physical Exam Findings: Disruption of articular arrangements of ankle, subtalar joint may be tested using ligamentous laxity tests.

iv. Diagnostic Testing Procedures: Radiographs, CT scans. MRI may be used to assess for avascular necrosis of the talus which may occur secondary to a dislocation.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Closed reduction under anesthesia with pre- and post-reduction neurovascular assessment followed by casting and weight-bearing limitations.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range of motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Inability to reduce closed fracture, association with unstable fractures

vii. Operative Procedures: Open or closed reduction of dislocation.

viii. Post-operative Treatment:

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Treatment usually includes initial immobilization with restricted weight-bearing, followed by bracing and active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

d. Ankle Sprain/Fracture

i. Description/Definition. An injury to the ankle joint due to abnormal motion of the talus that causes a stress on the malleolus and the ligaments. Injured ligaments in order of disruption include the anterior talofibular ligament (ATFL), calcaneofibular ligament (CFL), posterior talofibular ligament (PTFL), deltoid ligaments, and syndesmotomic ligaments. Instability can result from a fracture of a malleolus (malleoli), rupture of ligaments, or a combination. Circumstances surrounding the injury, including consideration of location and additional injuries are of importance. Additionally, the position of the foot at

the time of injury is helpful in determining the extent and type of injury. Grading of soft tissue injuries includes:

(a). Grade 1 Injury: those with overstretching or microscopic tears of the ligament, minimal swelling, normal stress testing, and the ability to bear weight.

(b). Grade 2 Injury: have partial disruption of the ligament, significant swelling, indeterminate results on stress testing, and difficulty bearing weight.

(c). Grade 3 Injury: have a ruptured ligament, swelling and ecchymosis, abnormal results on stress testing, and the inability to bear weight. May also include a chip avulsion fracture on x-ray.

ii. Occupational Relationship: sudden twisting, direct blunt trauma and falls. Inversion of the ankle with a plantar-flexed foot is the most common mechanism of injury.

iii. Specific Physical Exam Findings: varies with individual. With lower grade sprains the ankle may be normal appearing with minimal tenderness on examination. The ability/inability to bear weight, pain, swelling, or ecchymosis should be noted. If the patient is able to transfer weight from one foot onto the affected foot and has normal physical findings, then likelihood of fracture is reduced. Stress testing using the anterior drawer stress test, the talar tilt test and the external rotation stress test may be normal or abnormal depending on the involved ligament.

(a). Syndesmotic injury can occur with external rotation injuries and requires additional treatment. Specific physical exam tests include the squeeze test and external rotation at neutral.

iv. Diagnostic Testing Procedures: Radiographs. Refer to Initial Diagnostic Section which generally follows the Ottawa Ankle Rules. The Ottawa Ankle Rules are a decision aid for radiography. Commonly missed conditions include ankle syndesmosis or fractures. The instrument has a sensitivity of almost 100 percent and a modest specificity, and its use should reduce the number of unnecessary radiographs by 30 to 40 percent.

(a). For an acute, unstable ankle or a repeat or chronic ankle injury, a MRI and/or diagnostic injection may be ordered. Arthroscopy can be used in unusual cases with persistent functional instability and giving way of the ankle, after conservative treatment, to directly visualize the ruptured ligament(s).

#### v. Non-operative Treatment Procedures

(a). Initial treatment for patients able to bear weight: NSAIDs, RICE (rest, ice, compression and elevation), and early functional bracing is used. In addition, crutches may be beneficial for comfort. Early functional treatment including range of motion and strengthening exercises along with limited weight-bearing, are preferable to strict immobilization with rigid casting for improving outcome and reducing time to return to work.

(b). Initial treatment for patients unable to bear weight: bracing plus NSAIDs and RICE are used. When patient becomes able to bear weight a walker boot is frequently employed. There is no clear evidence favoring ten days of casting over pneumatic bracing as initial treatment for patients who cannot bear weight three days post injury. There is good evidence that use of either device combined with functional therapy results in similar long-term recovery.

(i). There is some evidence that functional rehabilitation has results superior to six weeks of immobilization.

(ii). Small avulsion fractures of the fibula with minimal or no displacement can be treated as an ankle sprain.

(iii). For patients with a clearly unstable joint, immobilize with a short leg plaster cast or splint for two to six weeks along with early weight-bearing.

(c). Balance/coordination training is a well-established treatment which improves proprioception and may decrease incidence of recurrent sprains.

(d). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(e). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(f). Heel wedges or other orthotics may be used for rear foot varus or valgus deformities.

(i). There is good evidence that semi-rigid orthoses or pneumatic braces prevent ankle sprains during high risk physical activities and they should be used as appropriate after acute sprains.

(g). When fractures are involved refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(h). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(i). Return-to-work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(j). Other therapies in Therapeutic Procedures, Non-operative, including manual therapy may be employed in individual cases.

(k). Hyperbaric oxygen therapy is not recommended.

#### vi. Surgical Indications/Considerations:

(a). Acute surgical indications include sprains with displaced fractures, syndesmotic disruption or ligament sprain associated with a fracture causing instability.

(b). There is no conclusive evidence that surgery as opposed to functional treatment for an uncomplicated Grade I-III ankle sprain improves patient outcome.

(c). Chronic indications are functional problems, such as recurrent instability, remaining after at least 2 months of appropriate therapy including active participation in a non-operative therapy program including balance training.

(d). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(e). If injury is a sprain: Smoking may affect soft tissue healing through tissue hypoxia. Patients should be

strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). If injury is a fracture: Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Treatment: Repair of fractures or other acute pathology as necessary. Primary ligament ankle reconstruction with possible tendon transplant.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. Treatment may include short-term post surgical casting. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(i). There is some evidence that more rapid recovery occurs with functional rehabilitation compared to six weeks of immobilization in a cast.

(b). The surgical procedures and the patient's individual results dictate the amount of time a patient has non weight-bearing restrictions. Fractures usually require six to eight weeks while tendon transfers may be six weeks. Other soft tissue repairs, such as the Brostrom lateral ankle stabilization, may be as short as three weeks.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

e. Calcaneal Fracture:

i. Description/Definition: Osseous fragmentation/separation confirmed by diagnostic studies.

ii. Occupational Relationship: Usually occurs by fall or crush injury.

iii. Specific Physical Exam Findings: Pain with range of motion and palpation of calcaneus. Inability to bear weight, mal-positioning of heel, possible impingement of sural nerve.

iv. Diagnostic Testing Procedures: Radiographs and CT scan to assess for intra-articular involvement. Lumbar films and urinalysis are usually performed to rule out lumbar crush fractures when the mechanism of injury is a fall from a height.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Non weight-bearing six to eight weeks, followed by weight-bearing cast at physician's discretion and active therapy with or without passive therapy.

(b). Medications such as analgesics and anti-inflammatory may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Displacement of fragments, joint depression, intra-articular involvement, mal-position of heel. Sanders Types II and III are generally repaired surgically. However, the need for surgery will depend on the individual case. Relative contraindications: smoking, diabetes, or immunosuppressive disease.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Open reduction internal fixation. Subtalar fusion may be necessary in some cases when the calcaneus is extremely comminuted. External fixation has been used when the skin condition is poor.

(a). Complications may include wound infections requiring skin graft.

viii. Post-operative Treatment:

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the therapies as outlined in Section F, Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). The patient is usually non weight-bearing for six to eight weeks followed by weight-bearing for approximately six to eight weeks at physician's discretion.

(c). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

f. Chondral and Osteochondral Defects:

i. Description/Definition: Cartilage or cartilage and bone defect of the talar surface. May be associated with ankle sprain or other injuries.

ii. Occupational Relationship: Usually caused by a traumatic ankle injury.

iii. Specific Physical Exam Findings: Ankle effusion, pain in joint and with walking.

iv. Diagnostic Testing Procedures: MRI may show bone bruising, osteochondral lesion, or possibly articular cartilage injury. Radiographs, contrast radiography, CT may also be used.

v. Non-Operative Treatment Procedures:

(a). Initial Treatment: Acute injuries may require immobilization followed by active therapy with or without passive therapy.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

#### vi. Surgical Indications/Considerations

(a). Functional deficits not responsive to conservative therapy. Identification of an osteochondral lesion by diagnostic testing procedures should be done to determine the size of the lesion and stability of the joint.

(b). Microfracture is the initial treatment unless there are other anatomic variants such as a cyst under the bone.

(c). Osteochondral Autograft Transfer System (OATS) may be effective in patients without other areas of osteoarthritis, a BMI of less than 35 and a failed microfracture. This procedure may be indicated when functional deficits interfere with activities of daily living and/or job duties 6 to 12 weeks after a failed microfracture with active patient participation in non-operative therapy. This procedure is only appropriate in a small subset of patients and requires prior authorization.

(d). Autologous cartilage cell implant is not FDA approved for the ankle and therefore not recommended.

(e). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(f). Smoking may affect tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Arthroscopy with debridement or shaving of cartilage, microfracture, mosaicplasty, fixation of loose osteochondral fragments.

#### viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

#### g. Heel Spur Syndrome/Plantar Fasciitis:

i. Description: Pain along the inferior aspect of the heel at the calcaneal attachment of the plantar fascia and/or along the course of the plantar fascia.

ii. Occupational Relationship: Condition may be exacerbated by prolonged standing or walking on hard surfaces. Acute injury may be caused by trauma. This may include jumping from a height or hyperextension of the forefoot upon the rear foot.

iii. Specific Physical Exam Findings: Pain with palpation at the inferior attachment of the plantar fascia to the os calcis may be associated with calcaneal spur. Gastrocnemius tightness may be tested with the Silfverskiöld test. The foot is dorsiflexed with the knee extended and then with the knee flexed. The test for gastrocnemius tightness is considered positive if dorsiflexion is greater with the knee flexed than with the knee extended.

iv. Diagnostic Testing Procedures: Standard radiographs to rule out fracture, identify spur after conservative therapy. Bone scans and/or MRI may be used to rule out stress fractures in chronic cases.

#### v. Non-operative Treatment Procedures:

(a). Initial Treatment: This condition usually responds to conservative management consisting of eccentric exercise of the gastrocnemius, plantar fascial stretching, taping, soft-tissue mobilization, night splints, and orthotics. Therapy may include passive therapy, taping, and injection therapy.

(b). Shock absorbing shoe inserts may prevent back and lower extremity problems in some work settings.

(c). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(d). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(e). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and range of motion. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age.

- (i). Time to Produce Effect: One injection.
- (ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.
- (iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). After four months of failed therapy, Extracorporeal Shock Wave Therapy (ESWT) trial may be considered prior to surgery. Refer to Therapeutic Procedures, Non-operative.

(h). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). Surgery is employed only after failure of at least four to six months of active patient participation in non-operative treatment.

(b). Indications for a gastrocnemius recession include a positive Silfverskiöld test. This procedure does not weaken the arch as may occur with a plantar fascial procedure, however, there is a paucity of literature on this procedure.

(c). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(d). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Treatment Procedures: Plantar fascial release with or without calcaneal spur removal, endoscopic or open gastrocnemius recession.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy. Usually non weight-bearing for 7 to 10 days followed by weight-bearing cast or shoe for four weeks; however, depending on the procedure some patients may be restricted from weight-bearing for four to six weeks.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

h. Metatarsal-Phalangeal, Tarsal-Metatarsal and Interphalangeal Joint Arthropathy:

i. Description/Definition: Internal derangement of joint.

ii. Occupational Relationship: Jamming, contusion, crush injury, repetitive impact, or post-traumatic arthrosis.

iii. Specific Physical Exam Findings. Pain with palpation and ROM of joint, effusion. The piano key test may be used, where the examiner stabilizes the heel with one hand and presses down on the distal head of the metatarsals, assessing for pain proximally.

iv. Diagnostic Testing Procedures. Radiographs, diagnostic joint injection, CT, MRI.

v. Non-operative Treatment Procedures

(a). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(b). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(c). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Orthotics and iontophoresis are usually included. A carbon fiber Morton extension may be useful. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(d). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and range of motion. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations

(a). Pain, unresponsive to conservative care and interfering with activities of daily living.

(b). First metatarsal arthritis or avascular necrosis can interfere with function and gait.

(c). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(d). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: if debridement of the arthritic joint and other conservative treatment is unsuccessful in correcting gait and walking tolerance, other procedures may be considered. Other procedures include: fusion of first metatarsal-phalangeal joint, chilectomy, osteotomies, Keller arthroplasty and soft tissue procedures.

(a). There is some evidence that the first metatarsal-phalangeal joint arthritis is better treated with arthrodesis than arthroplasty for pain and functional improvement. Therefore, total joint arthroplasties are not recommended for any metatarsal-phalangeal joints due to less successful outcomes than fusions. There may be an exception for first and second metatarsal-phalangeal joint arthroplasties when a patient is older than 60, has low activity levels, and cannot tolerate non weight-bearing for prolonged periods or is at high risk for non-union.

(b). Metallic hemi-arthroplasties are still considered experimental as long-term outcomes remain unknown in comparison to arthrodesis, and there is a significant incidence of subsidence. Therefore, these are not recommended at this time.

#### viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). For fusions and osteotomies, reduced weight-bearing and the use of special shoes will be necessary for at least six weeks post operative. For other procedures early range-of-motion, bracing, and/or orthotics. Treatment usually also includes other active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

##### i. Midfoot (Lisfranc) Fracture/Dislocation

i. Description/Definition: Fracture/ligamentous disruption of the tarsal-metatarsal joints, i.e., metatarsal-cuneiform and metatarsal-cuboid bones.

ii. Occupational Relationship: Usually occurs from a fall, crush, axial load with a plantar flexed foot, or abductory force on the forefoot.

iii. Specific Physical Exam Findings. Pain and swelling at the Lisfranc joint, first and/or second metatarsal cuneiform articulation, palpable dorsal dislocation, pain on forced abduction.

(a). Dislocation may not always be apparent. Pronation and supination of the forefoot with the calcaneus fixed in the examiners opposite hand may elicit pain in a Lisfranc injury, distinguishing it from an ankle sprain, in which this maneuver is expected to be painless. The piano key test may be used, where the examiner stabilizes the heel with one hand and presses down on the distal head of the metatarsal, assessing for pain proximally. The dorsalis pedis artery crosses the second metatarsal and may be disrupted. Therefore, the dorsalis pedis pulse and capillary filling should be assessed.

iv. Diagnostic Testing Procedures: X-rays, CT scans, MRI, mid-foot stress x-rays.

##### v. Non-operative Treatment Procedures:

(a). Initial Treatment: If minimal or no displacement then casting, non weight-bearing six to eight weeks. Orthoses may be used later.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Displacement of fragments or intra-articular fracture. Most Lisfranc fracture/dislocations are treated surgically.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Open reduction internal fixation with possible removal of hardware at approximately three to six months, pending healing status. Alternatively, arthrodesis of the medial two or three metatarsals.

##### viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using treatments as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). The patient is usually in cast or fracture walker for six to eight weeks non weight-bearing. Orthoses may be indicated after healing.

(c). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in

occupational medicine in consultation with the surgeon or by the surgeon.

j. Morton's Neuroma

i. Description. This condition is a perineural fibrosis of the intermetatarsal nerve creating pain and/or paresthesias in the forefoot region. Symptoms appear with weight-bearing activities. Usually occurs between the third and fourth metatarsals or between the second and third metatarsals.

ii. Occupational Relationship. Acute injuries may include excessive loading of the forefoot region caused from jumping or pushing down on the ball of the foot. Non-traumatic occurrences are determined at physician's discretion after review of environmental and biomechanical risk factors.

iii. Specific Physical Exam Findings. Paresthesias and/or pain with palpation of the inter-metatarsal nerve. Mulder's sign, a palpable click from compression of the nerve, or Tinel's sign.

iv. Diagnostic Testing Procedures. Radiographs to rule out osseous involvement. Diagnostic and therapeutic injections. Diagnosis is usually based on clinical judgment; however, MRI and ultrasound imaging have also been employed in difficult cases.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Nonsteroidal anti-inflammatories and foot orthoses are primary treatments.

(b). Medications such as analgesics and anti-inflammatories are usually helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and range of motion. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(e). Alcohol injections are thought to produce a chemical neurolysis. Alcohol injection with ultrasound guidance may be used to decrease symptoms.

(i). Optimum Duration: Four treatments.

(ii). Maximum Duration: Seven treatments.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). Functional deficits persisting after two to three months of active participation in therapy.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Excision of the neuroma; nerve transection or transposition.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Treatment may involve a period of non weight-bearing for up to two weeks, followed by gradual protected weight-bearing four to six weeks.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

k. Pilon Fracture

i. Description/Definition: Crush/comminution fracture of distal metaphyseal tibia that has intra-articular extensions into the weight-bearing surface of the tibio-talar joint.

ii. Occupational Relationship: Usually from a fall.

iii. Specific Physical Exam Findings: Swelling, pain with weight-bearing, ecchymosis, and palpable tenderness.

iv. Diagnostic Testing Procedures: Radiographs, CT scans.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Prolonged non weight-bearing at physician's discretion.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

Displacement of fracture, severe comminution necessitating primary fusion.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Open reduction internal fixation, fusion, external fixation. In some cases staged procedures may be necessary beginning with external fixation.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using treatment as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

1. Posterior Tibial Tendon Dysfunction

i. Description/Definition: Pain in the posteromedial ankle with plantar flexion.

ii. Occupational Relationship: Repetitive or forced plantar flexion after an ankle sprain or athletic activity.

iii. Specific Physical Exam Findings: Painful posterior tibial tendon with active and passive non weight-bearing motion, reproduction of pain with forced plantar flexion and inversion of the ankle, difficulty performing single heel raise, pain with palpation from the posterior medial foot along the medial malleolus to the navicular greater tuberosity. The patient should also be evaluated for a possible weak gluteus medius as a contributing factor.

iv. Diagnostic Testing Procedures: X-ray, MRI may be used to rule out other diagnoses.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Short ankle articulated orthosis and therapy including low-load strengthening exercises with progression to home program. Other active and passive therapy including iontophoresis, orthotics and possible strengthening for the gluteus medius.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(e). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). Failure of non-operative treatment. Surgery is rarely necessary as success rate for non-operative treatment is around 90 percent.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Resection of anomolous muscle segments or tenolysis. In severe cases, tendon transfer, osteotomies and/or arthrodesis may be necessary.

viii. Post-operative Treatment:

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-Operative.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

m. Puncture Wounds of the Foot

i. Description/Definition: Penetration of skin by foreign object.

ii. Occupational Relationship: Usually by stepping on foreign object, open wound.

iii. Specific Physical Exam Findings: Site penetration by foreign object consistent with history. In early onset, may show classic signs of infection.

iv. Diagnostic Testing Procedures: X-ray, MRI, ultrasound.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Appropriate antibiotic therapy, tetanus toxoid booster, non weight-bearing at physician's discretion.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(e). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Cellulitis, retained foreign body suspected, abscess, compartmental syndrome, and bone involvement.

(a). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Incision and drainage with cultures.

viii. Post-operative Treatment

(a). Patient is usually non-weight-bearing with antibiotic therapy based upon cultures. Follow-up x-rays and/or MRI may be needed to evaluate for osseous involvement.

(b). An individualized rehabilitation program based upon communication between the surgeon and the therapist using treatment as outlined in Therapeutic Procedures, Non-operative.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

n. Severe Soft Tissue Crush Injuries:

i. Description/Definition: Soft tissue damage to the foot.

ii. Occupational Relationship: Crush injury or heavy impact to the foot or ankle.

iii. Specific Physical Exam Findings: Pain and swelling over the foot.

iv. Diagnostic Testing Procedures: X-ray and other tests as necessary to rule out other possible diagnoses such as compartment syndrome which requires emergent compartment pressure assessment.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Usually needs initial rest from work with foot elevation and compression wraps.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by distal and proximal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: If compartmental pressures are elevated, emergent fasciotomy is warranted.

(a). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly

encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Emergency fasciotomy. In some cases a delayed primary closure is necessary.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Section F, Therapeutic Procedures, Non-operative.

(b). Treatment may include the following: elevation, restricted weight-bearing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

o. Stress Fracture

i. Description/Definition: Fracture without displacement usually to metatarsals, talus, navicular or calcaneus.

ii. Occupational Relationship: May be related to repetitive, high impact walking; running; or jumping.

iii. Specific Physical Exam Findings: Pain over the affected bone with palpation or weight-bearing.

iv. Diagnostic Testing Procedures: X-ray, CT, MRI, bone scan

v. Non-Operative Treatment Procedures

(a). Initial Treatment: Immobilization for four to eight weeks with limited weight-bearing may be appropriate.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). There is some evidence that shock absorbing boot inserts may decrease the incidence of stress fractures in military training. Shock absorbing boot inserts of other orthotics may be used in some cases after a stress fracture has occurred or to prevent stress fractures in appropriate work settings.

(g). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(h). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Fractures that have not responded to conservative therapy.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Most commonly percutaneous screws or plate fixation.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Section F, Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

p. Talar Fracture

i. Description/Definition: Osseous fragmentation of talus confirmed by radiographic, CT or MRI evaluation.

ii. Occupational Relationship: Usually occurs from a fall or crush injury.

iii. Specific Physical Exam Findings: Clinical findings consistent with fracture of talus: pain with range of motion, palpation, swelling, ecchymosis. Pain with weight-bearing attempt.

iv. Diagnostic Testing Procedures: Radiographs, CT scans, MRI. CT scans preferred for spatial alignment.

v. Non-Operative Treatment Procedures

(a). Initial Treatment: Non weight-bearing for six to eight weeks for non-displaced fractures.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Osseous displacement, joint involvement and instability.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Open reduction internal fixation.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication

between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include the following: Non weight-bearing six to eight weeks followed by weight-bearing cast. MRI follow-up if avascular necrosis is suspected. Active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

q. Tarsal Tunnel Syndrome

i. Description: Pain and paresthesias along the medial aspect of the ankle and foot due to nerve irritation and entrapment of the tibial nerve or its branches. These symptoms can also be caused by radiculopathy.

ii. Occupational Relationship: Acute injuries may occur after blunt trauma along the medial aspect of the foot. Non-traumatic occurrences are determined at physician's discretion after review of environmental and biomechanical risk factors. Non work related causes include space occupying lesions.

iii. Specific Physical Exam Findings: Positive Tinel's sign. Pain with percussion of the tibial nerve radiating distally or proximally. Pain and paresthesias with weight-bearing activities.

iv. Diagnostic Testing Procedures: Nerve conduction velocity studies of both sides for comparison to normal side. EMGs may be needed to rule out radiculopathy. MRI to rule out space occupying lesions. Diagnostic injections to confirm the diagnosis.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Cast or bracing, immobilization and foot orthoses are appropriate initial management.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Return to work with appropriate restrictions should be considered early in the course of treatment.

(i). Orthotics or accommodative footwear is usually necessary before workers can be returned to walking on hard surfaces. Refer to Return to Work.

(e). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations

(a). Continued functional deficits after active participation in therapy for three to six months.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly

encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Tarsal tunnel release with or without a plantar fascial release.

viii. Post-operative Treatment:

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-Operative.

(b). Treatment may include the following: restricted weight-bearing, orthotics, bracing, active therapy with or without passive therapy.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

r. Tendonopathy: For Achilles Tendonopathy, Refer to Specific Lower Extremity Injury Diagnosis, Testing and Treatment for other types of tendonopathy of the foot and ankle, General recommendations can be found in Tendonopathy of the Knee.

## 2. Knee

### a. Aggravated Osteoarthritis

i. Description/Definition: Swelling and/or pain in a joint due to an aggravating activity in a patient with pre-existing degenerative change in a joint. Age greater than 50 and morning stiffness lasting less than 30 minutes are frequently associated. The lifetime risk for symptomatic knee arthritis is probably around 45 percent and is higher among obese persons.

ii. Occupational Relationship: The provider must establish the occupational relationship by establishing a change in the patient's baseline condition and a relationship to work activities including but not limited to physical activities such as repetitive kneeling or crawling, squatting and climbing, or heavy lifting.

(a). Other causative factors to consider - Previous meniscus or ACL damage may predispose a joint to degenerative changes. In order to entertain previous trauma as a cause, the patient should have medical documentation of the following: meniscectomy; hemarthrosis at the time of the original injury; or evidence of MRI or arthroscopic meniscus or ACL damage. The prior injury should have been at least two years from the presentation for the new complaints and there should be a significant increase of pathology on the affected side in comparison to the original imaging or operative reports and/or the opposite un-injured side or extremity.

(b). Body mass index (BMI) of 25 or greater is a significant risk factor for eventual knee replacement.

iii. Specific Physical Exam Findings: Increased pain and/or swelling in a joint with joint line tenderness; joint crepitus; and/or joint deformity.

iv. Diagnostic Testing Procedures: Radiographs, The Kellgren-Lawrence Scale is the standard radiographic scale for knee osteoarthritis. It is based on the development of osteophytes, on bone sclerosis, and on joint space narrowing. The degree of joint space narrowing may not predict disability.

(a). Grade 1: doubtful narrowing of joint space, and possible osteophytic lipping.

(b). Grade 2: definite osteophytes, definite narrowing of joint space.

(c). Grade 3: moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour.

(d). Grade 4: large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour.

(e). MRI to rule out degenerative menisci tears. MRI may identify bone marrow lesions which are correlated with knee pain. These lesions may reflect increased water, blood, or other fluid inside bone and may contribute to the causal pathway of pain. These are incidental findings and should not be used to determine a final diagnosis nor make decisions regarding surgery.

v. Non-operative Treatment Procedures:

(a). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(b). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management. There is good evidence for self-management using weight loss, exercise, pacing of activities, unloading the joint with braces, insoles and possibly taping, and medications as needed. Patients should be encouraged to perform aerobic activity such as walking or biking. However, activities such as ladders, stairs and kneeling may be restricted.

(c). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal to proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Bracing may be appropriate in some instances. Refer to Section F., Therapeutic Procedures, Non-operative. There is good evidence that there is a small functional advantage for patients involved in exercise with physical therapy supervision over home exercise.

(i). There is some evidence that active physical therapy improves knee function more effectively than medication alone.

(ii). Aquatic therapy may be used as a type of active intervention when land-based therapy is not well-tolerated.

(iii). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative. There is some evidence that ice massage can improve ROM, strengthening of the knee and function. Ice can be used with proper instruction at home or under supervision for up to 20 minute periods 3 times per week or more frequently.

(d). Therapeutic Injections—both steroids and viscosupplementation may be used.

(i). There is good evidence that intra-articular corticosteroid injection is more effective than placebo in reducing pain from osteoarthritis. Optimum dosage is not known.

(ii). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM.

[a]. Time to Produce Effect: One injection.

[b]. Maximum Duration: Three injections in one year at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(iv). Viscosupplementation appears to have a longer lasting effect than intra-articular corticosteroids, however, the overall effect varies depending on the timing and the effect studied. Refer to Therapeutic Procedures.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

(g). Bracing such as knee immobilizer or hinge brace may be used for acute ACL injuries.

vi. Surgical Indications/Considerations.

(a). Arthroscopic Debridement and/or Lavage. There is good evidence from a randomized controlled trial that arthroscopic debridement alone provides no benefit over recommended therapy for patients with uncomplicated Grade 2 or higher arthritis. The comparison recommended treatment in the study followed the American College of Rheumatology guidelines which includes: patient education, and supervised therapy with a home program, instruction on ADLs, stepwise use of analgesics and hyaluronic acid injections if desired. Complicated arthritic patients excluded from the study included patients who required other forms of intervention due to the following associated conditions: large meniscal bucket handle tears, inflammatory or infectious arthritis, more than 5 degrees of varus or valgus deformity, previous major knee trauma, or Grade 4 arthritis in two or more compartments.

(i). Therefore, arthroscopic debridement and/or lavage are not recommended for patients with arthritic findings and continual pain and functional deficits unless there is meniscal or cruciate pathology. Refer to the specific conditions in Specific Lower Extremity Injury Diagnosis, Testing and Treatment, for specific diagnostic recommendations.

(b). Osteotomy and joint replacement are indicated when conservative treatment, including active participation in non-operative treatment has failed to result in sufficient functional improvement (Refer to Knee Arthroplasty, and Osteotomy). Tibial osteotomy is a choice for younger patients with unicompartamental disease who have failed conservative therapy.

(c). In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for

motivated patients who have demonstrated continual progress with weight loss.

(d). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(e). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Total or compartmental joint replacement, and osteotomy.

(a). Free-floating interpositional unicompartamental replacement is not recommended for any patients due to high revision rate at two years and less than optimal pain relief.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and therapist and using the treatments found in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Refer also to Knee Arthroplasty, or Osteotomy as appropriate.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

b. Anterior Cruciate Ligament (ACL) Injury

i. Description/Definition: Rupture or partial rupture of the anterior cruciate ligament; may be associated with other internal derangement of the knee.

ii. Occupational Relationship: May be caused by virtually any traumatic force to the knee but most often caused by a twisting or a hyperextension force, with a valgus stress. The foot is usually planted and the patient frequently experiences a “popping” feeling.

iii. Specific Physical Exam Findings: Findings on physical exam include effusion or hemarthrosis, instability, positive Lachman’s test, positive pivot shift test, and positive anterior drawer test.

iv. Diagnostic Testing Procedures: MRI. Radiographs may show avulsed portion of tibial spine but this is a rare finding.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Acute injuries may require immobilization followed by active therapy with or without passive therapy.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures bracing may be beneficial. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee (Refer to Therapeutic Procedures, Non-operative). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(i). There is no evidence that any particular exercise regime is better for ACL injuries in combination with collateral or meniscus injuries. There is no evidence that knee bracing for non operated ACL improves outcomes although patients may feel that they have greater stability. Non surgical treatment may provide acceptable results in some patients.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

iv. Surgical Indications/Considerations: any individual with complaints of recurrent instability interfering with function and physical findings with imaging consistent with an ACL injury.

(a). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(b). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

v. Operative Procedures

(a). Diagnostic/surgical arthroscopy followed by ACL reconstruction using autograft or allograft. If meniscus repair is performed, an ACL repair should be performed concurrently.

(b). Patients tend to have more pain associated with patellar grafts while patients with hamstring replacement seem to have an easier rehabilitation. Choice of graft is made by the surgeon and patient on an individual basis.

vi. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Treatment may include the following: active therapy with or without passive therapy and bracing. Early active extension does not cause increased laxity at two years.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

c. Bursitis of the Lower Extremity

i. Description/Definition: Inflammation of bursa tissue. Bursitis can be precipitated by tendonitis, bone spurs, foreign bodies, gout, arthritis, muscle tears, or infection.

ii. Occupational Relationship: Soft tissue trauma, contusion, or physical activities of the job such as sustained direct compression force, or other repetitive forceful activities affecting the knee.

iii. Specific Physical Exam Findings: Palpable, tender and enlarged bursa, decreased ROM, warmth. The patient may have increased pain with ROM.

iv. Diagnostic Testing Procedures: Lab work may be done to rule out inflammatory disease. Bursal fluid aspiration with testing for connective tissue, rheumatic disease, and infection may be necessary. Radiographs, CT, MRI are rarely indicated.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Diagnostic/therapeutic aspiration, ice, therapeutic injection, treatment of an underlying infection, if present. Aspirations may be repeated as clinically indicated.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, including a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal joints. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(e). Steroid Injections. Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be

reminded to check their blood glucose levels at least daily for two weeks after injections.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical indications/Considerations:

(a). Failure of conservative therapy.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Surgical excision of the bursa.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

d. Chondral and Osteochondral Defects

i. Description/Definition: Cartilage or cartilage and bone defect at the articular surface of a joint. Deficits may be identified in up to 60 percent of arthroscopies; however, only around 30 percent of these lesions are isolated deficits and even fewer are Grade III or IV deficits which might qualify for cartilage grafts.

(a). Defects in cartilage and bone are common at the femoral condyles and patella. The Outerbridge classification grades these defects according to their size and depth.

(i). Grade 0: normal cartilage.

(ii). Grade I: softening and swelling of cartilage.

(iii). Grade II: partial-thickness defects with surface fissures that do not exceed 1.5 cm in diameter and do not reach subchondral bone.

(iv). Grade III: fissuring that reaches subchondral bone in an area with a diameter greater than 1.5 cm.

(v). Grade IV: exposed subchondral bone.

ii. Occupational Relationship: Typically caused by a traumatic knee injury. Chondral deficits can also be present secondary to osteoarthritis.

iii. Specific Physical Exam Findings: Knee effusion, joint line tenderness.

iv. Diagnostic Testing Procedures: MRI may show bone bruising, osteochondral lesion, or possibly articular cartilage injury. Radiographs, contrast radiography, CT may

also be used. Diagnostic arthroscopy may be performed when surgical indications as stated in Section VI are met.

v. Non-Operative Treatment Procedures:

(a). Initial Treatment: Non-operative treatment may be indicated for chondral lesions associated with degenerative changes, refer to aggravated osteoarthritis; other knee lesions not requiring surgery (refer to Specific Diagnosis); and/or non-displaced stable lesions. Acute injuries may require immobilization followed by active therapy with or without passive therapy.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Section F.7, Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Surgery for isolated chondral defects may be indicated when functional deficits interfere with activities of daily living and/or job duties after 6 to 12 weeks of active patient participation in non-operative therapy. Identification of the lesion should have been accomplished by diagnostic testing procedures which describe the size of the lesion and stability of the joint. If a lesion is detached or has fluid underlying the bone on MRI, surgery may be necessary before a trial of conservative therapy is completed. Early surgery may consist of fixation or microfracture.

(a). Microfractures: Normally the first line of surgical treatment.

(i). Indications: An isolated small full-thickness articular chondral defect with normal joint space, when the patient has not recovered functionally after active participation in therapy. Patients 45 or younger are likely to have better results.

(b). Osteochondral Autograft Transfer System (OATS)

(i). Indications: The knee must be stable with intact ligaments and menisci, normal joint space and a

large full-thickness defect less than 3 square cm and 1 cm depth. They should be 45 or younger, with a BMI less than 35, and engaged in athletics and/or an equally physically demanding occupation. Surgery may be indicated when functional deficits interfere with activities of daily living and/or job duties after 6 to 12 weeks of active patient participation in non-operative therapy. This procedure may be appropriate in a small subset of patients and requires prior authorization.

(c). Autologous chondrocyte implantation (ACI): These procedures are technically difficult and require specific physician expertise. Cartilage transplantation requires the harvesting and growth of patients' cartilage cells in a highly specialized lab and incurs significant laboratory charges. There is some evidence that transplants and microfractures do not differ on long-term effects. There is some evidence that autologous chondrocyte implantation is not better than microfracture five years after surgery in patients younger than 45 presenting with Grade III -IV lesions. This procedure is controversial but may be appropriate in a small subset of patients with physically rigorous employment or recreational activities. It requires prior authorization.

(i). Indications: The area of the lesion should be between 2 square cm and 10 square cm. The patient should have failed four or more months of active participation in therapy and a microfracture, abrasion, arthroplasty or drilling with sufficient healing time, which may be from four months to over one year. The knee must be stable with intact ligaments and meniscus, and normal joint space. Patients should be 45 or younger, with a BMI less than 35, and engaged in athletics and/or an equally physically demanding occupation.

(d). Contraindications: General contraindications for grafts and transplants are individuals with obesity, inflammatory or osteoarthritis with multiple chondral defects, associated ligamentous or meniscus pathology, or who are older than 55 years of age.

(e). Prior to either graft or implantation intervention the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(f). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Arthroscopy with debridement or shaving of cartilage, microfracture, drilling, abrasion arthroplasty, mosaicplasty or osteochondral autograft (OATS), fixation of loose osteochondral fragments and autologous chondrocyte implantation (ACI).

(a). Radiofrequency treatment is not recommended.

#### viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the

therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include the following: restricted weight-bearing, bracing, active therapy with or without passive therapy. Full weight-bearing usually occurs by or before 8 weeks.

(c). Continuous passive motion may be used after chondral procedures.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon. Return to full-duty usually occurs by between four and six months.

#### (e). Collateral Ligament Pathology

(i). Description/Definition: Strain or tear of medial or lateral collateral ligaments which provide some stabilization for the knee.

(ii). Occupational Relationship: Typically a result of forced abduction and external rotation to an extended or slightly flexed knee.

(iii). Specific Physical Exam Findings: Swelling or ecchymosis over the collateral ligaments and increased laxity or pain with applied stress.

(iv). Diagnostic Testing Procedures: X-rays to rule out fracture. Imaging is more commonly ordered when internal derangement is suspected.

#### (v). Non-Operative Treatment Procedures

[a]. Initial Treatment: braces, ice, and protected weight-bearing.

[b]. Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions area in Medications and Medical Management.

[c]. Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

[d]. Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Bracing may be beneficial. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

[i]. Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

[e]. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

[f]. Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Surgery is rarely necessary except when functional instability persists after active participation in non-operative treatment or indications for surgery exist due to other accompanying injuries.

(a). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(b). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Surgical repair.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using procedures as outlined in Therapeutic Procedures, Non-operative.

(b). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

f. Meniscus Injury

i. Description/Definition—a tear, disruption, or avulsion of medial or lateral meniscus tissue. Locking of the knee or clicking is frequently reported. Patients may describe a popping, tearing, or catching sensation followed by stiffness.

ii. Occupational Relationship—trauma to the menisci from rotational shearing, torsion, and/or impact injuries while in a flexed position.

iii. Specific Physical Exam Findings: Joint line tenderness, Positive McMurray's test locked joint, or occasionally, effusion. The presence of joint line tenderness has a sensitivity of 85 percent and a specificity of 31 percent. The Apley's compression test is also used.

iv. Diagnostic Testing Procedures. Radiographs including standing Posterior/Anterior (PA), lateral, tunnel, and skyline views. MRI is the definitive imaging test. MRI is sensitive and specific for meniscal tear. However, meniscal MRI is frequently abnormal in asymptomatic injuries. In one study of volunteers without a history of knee pain, swelling, locking, giving way, or any knee injury, 16 percent of the volunteers had MRI-evident meniscal tears; among volunteers older than 45, 36 percent had MRI-evident meniscal tears. Therefore, clinical correlation with history and physical exam findings specific for meniscus injury is critically important.

(a). Providers planning treatment should therefore consider the patient's complaints and presence of arthritis on MRI carefully, knowing that not all meniscus tears in the middle aged and older population are related to the patients' complaints of pain.

(b). MRI arthrograms are used to diagnose recurrent meniscal tears particularly after previous surgery.

v. Non-operative Treatment

(a). Initial Treatment: ice, bracing, and protected weight-bearing.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Locked or blocked knee precluding active therapy; Isolated acute meniscus tear with appropriate physical exam findings; Meniscus pathology combined with osteoarthritis in a patient with functional deficits interfering with activities of daily living and/or job duties after 6 to 12 weeks of active patient participation in non-operative therapy.

(a). It is not clear that partial meniscectomy for a chronic degenerative meniscal tear is beneficial. Middle aged patients may do as well without arthroscopy and with therapy.

(b). Meniscal allograft should only be performed on patients between 20 and 45 with an otherwise stable knee, previous meniscectomy with 2/3 removed, lack of function despite active therapy, BMI less than 35, and sufficient joint surface to support repair.

(c). Medial collagen meniscus implants are considered experimental and not generally recommended. No studies have been done to compare this procedure to medial meniscus repair. There is some evidence to support the fact that collagen meniscal implant may slightly improve function and decrease risk of reoperation in patients with previous medial meniscal surgery. It remains unclear as to the extent that the procedure may decrease future degenerative disease. The procedure can only be considered for individuals with previous medial meniscal surgery and intact meniscus rim; without lateral meniscus lesions or Grade 4 Outerbridge lesions; and who need to return to heavy physical labor employment or demanding recreational activities. A second concurring opinion from an orthopedic surgeon specializing in knee surgery and prior authorization

is required. Full weight-bearing is not allowed for 6 weeks and most patients return to normal daily activity after three months.

(d). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(e). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Treatment: Repair of meniscus, partial or complete excision of meniscus or meniscus allograft or implant. Debridement of the meniscus is not recommended in patients with severe arthritis as it is unlikely to alleviate symptoms. Complete excision of meniscus should only be performed when clearly indicated due to the long-term risk of arthritis in these patients. Partial meniscectomy or meniscus repair is preferred to total meniscectomy due to easier recovery, less instability, and short-term functional gains.

#### viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative.

(b). Treatment may include the following: Passive therapy progressively moving toward active therapy, bracing, cryotherapy and other treatments found in Therapeutic procedures Non-Operative.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

#### g. Patellar Fracture

i. Description/Definition: Fracture of the patella.

ii. Occupational Relationship: Usually from a traumatic injury such as a fall or direct blow

iii. Specific Physical Exam Findings: Significant hemarthrosis/effusion usually present. Extension may be limited and may indicate disruption of the extensor mechanism. It is essential to rule out open fractures; therefore a thorough search for lacerations is important.

iv. Diagnostic Testing Procedures. Aspiration of the joint and injection of local anesthetic may aid the diagnosis. A saline load injected in the joint can also help rule out an open joint injury. Radiographs may be performed, including tangential (sunrise) or axial views and x-ray of the opposite knee in many cases. CT or MRI is rarely needed.

#### v. Non-Operative Treatment Procedures

(a). Initial Treatment: For non-displaced closed fractures, protected weight-bearing and splinting for four to six weeks. Hinged knee braces can be used. When radiographs demonstrate consolidation, active motion and strengthening exercise may begin.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions, after boney union has been achieved. They should include bracing then range-of-motion (ROM), active therapies including proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, restoring normal joint mechanics, influenced by proximal and distal structures. Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate. Bracing may be appropriate. Refer to Section F., Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(h). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(i). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Open fractures require immediate intervention and may need repeat debridement. Internal fixation is usually required for comminuted or displaced fractures. Non-union may also require surgery.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: internal fixation; partial patellectomy or total patellectomy. Total patellectomy results in instability with running or stairs and significant loss of extensor strength. Therefore, this is usually a salvage procedure.

#### viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions. Continuous passive motion may be used post operatively.

(b). Treatment may include protected weight-bearing and active therapy with or without passive therapy for early range of motion if joint involvement.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

(d). Hardware removal may be necessary after three to six months.

h. Patellar Subluxation:

i. Description/Definition: Incomplete subluxation or dislocation of the patella. Recurrent episodes can lead to subluxation syndrome that can cause frank dislocation of the patella. Patient may report a buckling sensation, pain with extension, or a locking of the knee with exertion.

ii. Occupational Relationship: Primarily associated with a direct contact lateral force. Secondary causes associated with shearing forces on the patella.

iii. Specific Physical Exam Findings: Lateral retinacular tightness with associated medial retinacular weakness, swelling, effusion, and marked pain with patellofemoral tracking/compression and glides. In addition, other findings may include atrophy of muscles, positive patellar apprehension test, and patella alta.

iv. Diagnostic Testing Procedures: CT or Radiographs including Merchant views, Q-angle, and MRI for loose bodies.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Reduction if necessary, ice, taping, and bracing followed by active therapy.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Taping the patella or bracing may be beneficial. Passive as well as active therapies can be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Specific strengthening should be done to optimize patellofemoral mechanics and address distal foot mechanics that influence the patellofemoral joint. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations

(a). Fracture, loose bodies, and recurrent dislocation. Surgical repair of first-time dislocation in young adults generally is not recommended. Retinacular release, quadriceps reefing, and patellar tendon transfer should only be considered for subluxation after four to six months of active patient participation in non-operative treatment.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: arthroscopy with possible arthrotomy; debridement of soft tissue and articular cartilage disruption; open reduction internal fixation with fracture; retinacular release, quadriceps reefing, and patellar tendon or lateral release with or without medial soft-tissue realignment.

viii. Post-operative Treatment:

(a). Individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative.

(b). Treatment may include active therapy with or without passive therapy, bracing.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

i. Patellofemoral Pain Syndrome (aka Retropatellar Pain Syndrome)

i. Description/Definition: Patellofemoral pathologies are associated with resultant weakening, instability, and pain of the patellofemoral mechanism. Diagnoses can include patellofemoral chondromalacia, malalignment, persistent quadriceps tendonitis, distal patellar tendonitis, patellofemoral arthrosis, and symptomatic plica syndrome. Patient complains of pain, instability and tenderness that interfere with daily living and work functions such as sitting with bent knees, climbing stairs, squatting, running or cycling.

ii. Occupational Relationship: Usually associated with contusion; repetitive patellar compressive forces; shearing articular injuries associated with subluxation or dislocation of patella, fractures, and/or infection.

iii. Specific Physical Exam Findings: Findings on physical exam may include retinacular tenderness, pain with patellar compressive ranging, positive patellar glide test, atrophy of quadriceps muscles, positive patellar apprehensive test. Associated anatomical findings may include increased Q angle; ligament laxity, and effusion. Some studies suggest that the patellar tilt test (assessing the patella for medial tilt) and looking for active instability with the patient supine and knee flexed to 15 degrees and an

isometric quad contraction, may be most useful for distinguishing normal from abnormal. Most patellar tests are more specific than sensitive.

iv. Diagnostic Testing Procedures: Radiographs including tunnel view, axial view of patella at 30 degrees, lateral view and Merchant views. MRI rarely identifies pathology. Occasional CT or bone scans.

v. Non-Operative Treatment Procedures:

(a). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(b). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(c). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. The program should include bracing and/or patellar taping, prone quad stretches, hip external rotation, balanced strengthening, range-of-motion (ROM), active therapies and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Active therapeutic exercise appears to decrease pain; however, the expected functional benefits are unclear. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Section F., Therapeutic Procedures, Non-operative. Orthotics may be useful in some cases.

(d). Knee pain, when associated with abnormal foot mechanics, may be favorably treated with appropriate orthotics.

(i). There is some evidence that pre-fabricated commercially available foot orthotic devices are more beneficial for patients with patellofemoral pain syndrome than flat shoe inserts. They may produce mild side effects such as rubbing or blistering which can be reduced with additional empirical measures such as heat molding or addition, and removal of wedges and inserts until patient comfort is achieved. In some cases, custom semi-rigid or rigid orthotics is necessary to decrease pronation or ensure a proper fit. There is no evidence regarding which orthotic design might be useful.

(e). Botulinum toxin injections for the relief of patellofemoral pain are considered experimental and are not recommended.

(f). Steroid Injections

(i). Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections near the patellar tendon should generally

be avoided. Injections should be minimized for patients less than 30 years of age.

[a]. Time to Produce Effect: One injection.

[b]. Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(ii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(g). Extracorporeal Shock Wave Therapy (ESWT): There is no good research to support ESWT and therefore, it is not recommended.

(h). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(i). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: patellar tendon disruption, quadriceps tendon rupture/avulsion, fracture. There is no evidence that surgery is better than eccentric training for patellar tendonopathy of the inferior pole (jumper's knee).

(a). Retinacular release, quadriceps reefing, and tibial transfer procedures should only be considered after four to six months of active patient participation in non-operative treatment in young active patients. There is no evidence that arthroscopy for patellofemoral syndrome is more efficacious than exercise.

(b). Lateral release and reconstruction is not recommended for patellofemoral arthritis or middle aged adults.

(c). In cases of severe Grade III-IV isolated patellofemoral arthritis where walking, steps, and other functional activities are significantly impacted after adequate conservative treatment, prosthesis may be considered in those less than 55 years. A patellofemoral arthroplasty is generally contraindicated if there is patellofemoral instability or malalignment, tibiofemoral mechanical malalignment, fixed loss of knee motion (greater than 10 degrees extension or less than 110 degrees flexion), inflammatory arthritis, and other systemic related issues. For patellar resurfacing, refer to Knee Arthroplasty.

(d). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(e). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii Operative Procedures: Arthroscopic debridement of articular surface, plica, synovial tissue, loose bodies; arthrotomy; open reduction internal fixation with fracture; patellar prosthesis with isolated Grade III-IV OA, and possible patellectomy for young active patients with isolated arthritis.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative.

(b). Treatment may include active therapy with or without passive therapy; and bracing.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

j. Posterior Cruciate Ligament (PCL) Injury

i. Description/Definition: Rupture of PCL. May be associated with concurrent ACL rupture or collateral ligament injury.

ii. Occupational Relationship. Most often caused by a posterior force directed to flexed knee.

iii. Specific Physical Exam Findings: Findings on physical exam include acute effusion, instability, reverse Lachman's test, reverse pivot shift, posterior drawer test.

iv. Diagnostic Testing Procedures: MRI, radiographs including kneeling view, may reveal avulsed bone.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: Ice, bracing, and protected weight-bearing followed by active therapy.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include bracing then range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). Carefully consider the patients' normal daily activity level before initiation of surgical intervention. Isolated Grade 1 instability does not require surgical intervention. Grades 2 or 3 may have surgical intervention if there remains demonstrable instability which interferes with athletic or work pursuits of the patient. In a second degree strain there is significant posterior motion of the tibia on the

femur in active testing. A third degree strain demonstrates rotary instability due to medial or lateral structural damage. Surgery is most commonly done when the PCL rupture is accompanied by multi-ligament injury. Not recommended as an isolated procedure in patients over 50 with Grade 3 or 4 osteoarthritis.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vi. Operative Procedures: Autograft or allograft reconstruction.

vii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Section F. Therapeutic Procedures, Non-operative.

(b). Treatment may include active therapy with or without passive therapy, bracing.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

k. Tendonopathy

i. Description/Definition. Inflammation of the lining of the tendon sheath or of the enclosed tendon. Usually occurs at the point of insertion into bone or a point of muscular origin. Can be associated with bursitis, calcium deposits, or systemic connective diseases.

ii. Occupational Relationship: Extreme or repetitive trauma, strain, or excessive unaccustomed exercise or work.

iii. Specific Physical Exam Findings: Involved tendons may be visibly swollen with possible fluid accumulation and inflammation; popping or crepitus; and decreased ROM.

iv. Diagnostic Testing Procedures. Lab work may be done to rule out inflammatory disease. Other tests are rarely indicated.

v. Non-Operative Treatment Procedures

(a). Initial Treatment: Ice, protected weight-bearing and/or restricted activity, possible taping and/or bracing.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active

therapies, including a home exercise program. Active therapies include, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from distal and proximal structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by structures distal and proximal to the knee. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(e). For isolated patellar tendonopathy, patellar tendon strapping or taping may be appropriate.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(g). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

(h). Therapeutic Injections: Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM. Steroid injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients less than 30 years of age.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

vi. Surgical Indications/Considerations:

(a). Suspected avulsion fracture, or severe functional impairment unresponsive to a minimum of four months of active patient participation in non-operative treatment.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Tendon repair. Rarely indicated and only after extensive conservative therapy.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-Operative.

(b). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

3. Hip and Leg

a. Acetabular Fracture

i. Description/Definition: Subgroup of pelvic fractures with involvement of the hip articulation.

ii. Occupational Relationship: Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings: Displaced fractures may have short and/or abnormally rotated lower extremity.

iv. Diagnostic Testing Procedures: Radiographs, CT scanning.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Although surgery is frequently required, protected weight-bearing may be considered for un-displaced fractures or minimally displaced fractures that do not involve the weight-bearing surface of the acetabular dome.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments on osteoporosis in Ankle Sprain/Fracture.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions, after bony union has been achieved. They should include bracing then range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include ambulation with appropriate assistive device, proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate. Bracing may be appropriate. Refer to Therapeutic Procedures, Non-Operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(g). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(h). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations. Displaced or unstable fracture.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that

insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Usually open reduction and internal fixation or total hip replacement.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist, and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

(b). Treatment usually includes active therapy with or without passive therapy for early range of motion and weight-bearing then progression to, strengthening, flexibility, neuromuscular training, and gait training with appropriate assistive devices.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

b. Aggravated Osteoarthritis

i. Description/Definition: hip pain with radiographic evidence of joint space narrowing or femoral acetabular osteophytes, and sedimentation rate less than 20mm/hr with symptoms. Patients usually have gradual onset of pain increasing with use and relieved with rest, progressing to morning stiffness and then to night pain.

ii. Occupational Relationship: The provider must establish the occupational relationship by establishing a change in the patient's baseline condition and a relationship to work activities including but not limited to repetitive heavy lifting or specific injury to the hip.

(a). Other causative factors to consider: Prior significant injury to the hip may predispose the joint to osteoarthritis. In order to entertain previous trauma as a cause, the patient should have a medically documented injury with radiographs or MRI showing the level of anatomic change. The prior injury should have been at least two years from the presentation for the new complaints and there should be a significant increase of pathology on the affected side in comparison to the original imaging or operative reports and/or the opposite un-injured side or extremity.

iii. Specific Physical Exam Findings: Bilateral exam including knees and low back is necessary to rule out other diagnoses. Pain with the hip in external and/or internal hip rotation with the knee in extension is the strongest indicator.

iv. Diagnostic Testing Procedures: standing pelvic radiographs demonstrating joint space narrowing to 2 mm or less, osteophytes or sclerosis at the joint. MRI may be ordered to rule out other more serious disease.

v. Non-Operative Treatment Procedures

(a). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(b). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management. Patient education may also include videos, telephone, follow-up, and pamphlets.

(c). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies and a home exercise program. Active therapies include gait training with appropriate assistive devices, proprioception training restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate Refer to Therapeutic Procedures, Non-operative. There is good evidence that a supervised therapeutic exercise program with an element of strengthening is an effective treatment for hip osteoarthritis.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative. There is some evidence that manual therapy, including stretching and traction manipulation by a trained provider, produces functional improvement in hip osteoarthritis and may be a suitable treatment option.

[a]. Aquatic therapy may be used as a type of active intervention to improve muscle strength and range of motion when land-based therapy is not well-tolerated.

[b]. The use of insoles, adaptive equipment, cane, may be beneficial.

[c]. There is some evidence that acupuncture may produce improvement in hip pain and function, making it a suitable treatment option for patients. Refer to Therapeutic Procedures, Non-operative.

[d]. Steroid Injections - Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM.

[i]. Time to Produce Effect: One injection.

[ii]. Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

[iii]. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

[e]. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

[f]. Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations

(a). When pain interferes with ADLs and the patient meets the following: low surgical risk, adequate bone quality, and failure of previous non-surgical interventions including weight control, therapy with active patient participation, and medication. Refer to 5 Therapeutic Procedures-operative, Hip Arthroplasty, for indications specific to the procedure.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals

and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

(d). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Prosthetic replacement (traditional or minimally invasive), or resurfacing.

viii. Post-Operative Treatment

(a). In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). For prosthetic replacement, refer to Hip Arthroplasty.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

c. Femoral Osteonecrosis (Avascular Necrosis (AVN) of the Femoral Head)

i. Description/Definition. Death of the bone tissue of the femoral head following loss of blood supply to the area. Destruction of the articular surfaces of the hip joint may lead to arthritis.

ii. Occupational Relationship. Trauma resulting in displaced subcapital fracture of the hip or hip dislocation may cause AVN. Previous surgical procedures and systemic steroids may lead to AVN. In the general population risk factors include, but are not limited to alcohol abuse, smoking, Caisson disease (also known as the bends), sickle cell anemia, autoimmune disease, and hypercoagulable states. Often, the cause cannot be identified. Involvement of the opposite hip may occur in more than half of cases not caused by trauma.

iii. Specific Physical Exam Findings. Hip or groin pain made worse by motion or weight-bearing and alleviated by rest is the classical presentation. Symptoms may begin gradually, often months after the vascular compromise of blood flow. A limp may result from the limited toleration of weight-bearing.

iv. Diagnostic Testing Procedures. X-ray abnormalities include sclerotic changes, cystic lesions, joint space narrowing, and degeneration of the acetabulum. The x-ray may be normal in the first several months of the disease process. AVN should be suspected when hip pain occurs and risk factors are present. X-rays should be done first, but may be followed by an MRI. When AVN is not due to trauma, both hips should be imaged.

v. Non-operative Treatment Procedures

(a). Initial Treatment: protected weight-bearing and bracing followed by active therapy with or without passive therapy. Conservative approaches may suffice when the lesion is small, but larger lesions are expected to require surgical intervention when symptoms are disabling.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management. Weight-bearing restrictions may be appropriate.

(d). Smoking may affect bone healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative, may be employed in individual cases.

vi. Surgical Indications/Considerations: Core decompression may appropriate for some patients with early disease (Stages 1 and 2A) who have functionally disabling symptoms. Femoral head osteotomies or resurfacing hemiarthroplasties may also be appropriate for younger patients when disease is limited to the femoral head. Those 50 or older and patients with total joint collapse or severely limiting disease will usually require an implant arthroplasty.

(a). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(b). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures. Osteotomy, core decompression with or without bone graft, prosthetic replacement. Refer to Section G., Therapeutic Procedures-operative for details.

viii. Post-operative Treatment

(a). Anticoagulant therapy to prevent deep venous thrombosis for most procedures. Refer to Therapeutic Procedures, Non-operative.

(b). Treatment usually includes active therapy with or without passive therapy. Refer to Therapeutic Procedures-Operative and specific procedures for further details.

(c). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative.

(d). Treatment should include gait training with appropriate assistive devices.

(e). Therapy should include training on the use of adaptive equipment and home and work site evaluation when appropriate.

(f). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon

d. Femur Fracture

i. Description/Definition. Fracture of the femur distal to the lesser trochanter.

ii. Occupational Relationship. Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings: May have a short, abnormally rotated extremity. Effusion if the knee joint is involved.

iv. Diagnostic Testing Procedures: Radiographs. Occasionally CT scan or MRI particularly if the knee joint is involved.

v. Non-operative Treatment Procedures

(a). Initial Treatment. Although surgery is usually required, non-operative procedures may be considered in stable, non-displaced fractures and will require protected weight-bearing.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Back pain may occur after femur fracture and should be addressed and treated as necessary.

(d). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, weight management. Weight-bearing restrictions may be appropriate.

(e). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(f). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(g). Orthotics such as heel lifts and custom shoe build-ups may be required when leg-length discrepancy persists.

(h). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(i). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations. Femoral neck fracture or supracondylar femur fracture with joint incongruity.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Rod placement or open internal fixation.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist, using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication

between the physician and the therapist is important to the timing of weight-bearing and exercise progression.

(b). Treatment usually includes active therapy with or without passive therapy for protected weight-bearing, early range of motion if joint involvement.

(c). Refer to bone-growth stimulators in Therapeutic Procedures, Non-operative.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

(e). Hamstring Tendon Rupture

(i). Description/Definition. Most commonly, a disruption of the muscular portion of the hamstring. Extent of the tear is variable. Occasionally a proximal tear or avulsion. Rarely a distal injury.

(ii). Occupational Relationship: Excessive tension on the hamstring either from an injury or from a rapid, forceful contraction of the muscle.

(iii). Specific Physical Exam Findings: Local tenderness, swelling, ecchymosis.

(iv). Diagnostic Testing Procedures: Occasionally radiographs or MRI for proximal tears/possible avulsion.

(v). Non-operative Treatment Procedures

[a]. Initial Treatment: Protected weight-bearing and ice.

[b]. Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

[c]. Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, and weight management.

[d]. Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They may include range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Bracing may be appropriate. Refer to Therapeutic Procedures, Non-operative.

[i]. Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

[e]. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

[f]. Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations

(a). Surgery is indicated for proximal or distal injuries only when significant functional impairment is expected without repair. If surgery is indicated, it is preferably performed within three months.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Re-attachment of proximal avulsions and repair of distal tendon disruption.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include protected weight-bearing and active therapy with or without passive therapy. Splinting in a functional brace may reduce time off work.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

f. Hip Dislocation

i. Description/Definition. Disengagement of the femoral head from the acetabulum.

ii. Occupational Relationship. Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings: Most commonly a short, internally rotated, adducted lower extremity with a posterior dislocation and a short externally rotated extremity with an anterior dislocation.

iv. Diagnostic Testing Procedures: Radiographs, CT scanning.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Urgent closed reduction with sedation or general anesthesia.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include bracing then range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, gait training with appropriate assistive devices, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures.

Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate. Bracing may be appropriate. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations: Failure of closed reduction. Associated fracture of the acetabulum or femoral head, loose fragments in joint or open fracture.

(a). Because smokers have a higher risk of non-union and post-operative costs, when a fracture is involved it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures. Open reduction of the femoral head or acetabulum and possible internal fixation.

viii. Post-operative Treatment Procedures

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment should include gait training with appropriate assistive devices.

(c). Treatment may include protected weight-bearing and active therapy with or without passive therapy for early range of motion.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

g. Hip Fracture

i. Description/Definition. Fractures of the neck and peri-trochanteric regions of the proximal femur.

ii. Occupational Relationship: Usually from a traumatic injury such as a fall or crush. Patients with intracapsular femoral fractures have a risk of developing avascular necrosis of the femoral head requiring treatment months to years after the initial injury.

iii. Specific Physical Exam Findings. Often a short and externally rotated lower extremity.

iv. Diagnostic Testing Procedures: Radiographs. Occasional use of CT scan or MRI.

v. Non-operative Treatment Procedures

(a). Initial Treatment: protected weight-bearing and bracing followed by active therapy with or without passive therapy. Although surgery is usually required, non-operative procedures may be considered in stable, non-displaced fractures.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Back pain may occur after hip fracture and should be addressed and treated as necessary.

(d). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management. Weight-bearing restrictions may be appropriate.

(e). Refer to comments on osteoporosis in Ankle Sprain/Fracture.

(f). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(g). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(h). Other therapies in Therapeutic Procedures, Non-operative, may be employed in individual cases.

vi. Surgical Indications/Considerations. Surgery is indicated for unstable peritrochanteric fractures and femoral neck fractures.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Prosthetic replacement for displaced femoral neck fractures. Reduction and internal fixation for peritrochanteric fractures, and un-displaced, or minimally-displaced neck fractures.

viii. Post-operative Treatment:

(a). Anti coagulant therapy to prevent deep venous thrombosis. Refer to Therapeutic Procedures, Non-operative.

(b). Treatment usually includes active therapy with or without passive therapy.

(c). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative.

(d). Treatment should include gait training with appropriate assistive devices.

(e). Therapy should include training on the use of adaptive equipment and home and work site evaluation when appropriate.

(f). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

h. Impingement/Labral Tears

i. Description/Definition: Two types of impingement are described pincer; resulting from over coverage of the acetabulum and/or cam; resulting from aspherical portion of the head and neck junction. Persistence of these abnormalities can cause early arthritis or labral tears. Labral tears can also be isolated; however, they are frequently accompanied by bony abnormalities. Patients usually complain of catching or painful clicking which should be distinguished from a snapping iliopsoas tibial tendon. A pinch while sitting may be reported and hip or groin pain.

ii. Occupational Relationship: Impingement abnormalities are usually congenital; however, they may be

aggravated by repetitive rotational force or trauma. Labral tears may accompany impingement or result from high energy trauma.

iii. Specific Physical Exam Findings. Positive labral tests.

iv. Diagnostic Testing Procedures. Cross table laterals, standing AP pelvis and frog leg lateral x-rays. MRI may reveal abnormality; however, false positives and false negatives are also possible. MRI arthrogram with gadolinium should be performed to diagnose labral tears, not a pelvic MRI. Intra-articular injection should help rule out extra-articular pain generators. To confirm the diagnosis, the patient should demonstrate changes on a pain scale accompanied by recorded functional improvement post-injection. This is important, as labral tears do not always cause pain and over-diagnosis is possible using imaging alone.

v. Non-Operative Treatment Procedures

(a). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(b). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, reducing hip adduction and internal rotation home exercise, joint protection, and weight management.

(c). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(d). Steroid Injections. Steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM.

(i). Time to Produce Effect: One injection.

(ii). Maximum Duration: Three injections in one year spaced at least four to eight weeks apart.

(iii). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations:

(a). Surgery is indicated when functional limitations persist after eight weeks of active patient participation in treatment, there are clinical signs and symptoms suggestive of the diagnosis and other diagnoses have been ruled out.

(b). Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

(c). In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

(d). Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

vii. Operative Procedures: Debridement or repair of labrum and removal of excessive bone.

viii. Post-operative Treatment

(a). When bone is removed and/or the labrum is repaired, weight-bearing restrictions usually apply.

(b). An individualized rehabilitation program based upon communication between the surgeon and the therapist that should include gait training with appropriate assistive devices. Refer to Therapeutic Procedures Non-operative.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

i. Pelvic Fracture

i. Description/Definition. Fracture of one or more components of the pelvic ring (sacrum and iliac wings).

ii. Occupational Relationship. Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings. Displaced fractures may cause pelvic deformity and shortening, or rotation of the lower extremities.

iv. Diagnostic Testing Procedures: Radiographs, CT scanning. Occasionally MRI, angiogram, urethrogram, emergent sonogram.

v. Non-operative Treatment Procedures

(a). Initial Treatment: Protected weight-bearing. Although surgery is usually required, non-operative procedures may be considered in a stable, non-displaced fracture.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions, after bony union has been achieved. They should include bracing then range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include, proprioception training, gait training with appropriate assistive devices, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as adjunctive in Therapeutic Procedures, Non-operative.

(g). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(h). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations. Unstable fracture pattern, or open fracture.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures. External or internal fixation dictated by fracture pattern.

viii. Post-Operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment usually includes active therapy with or without passive therapy for gait, pelvic stability, strengthening, and restoration of joint and extremity function. Treatment should include gait training with appropriate assistive devices.

(c). Graduated weight-bearing according to fracture healing.

(d). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

j. Tendonopathy: Refer to Tendonopathy for general recommendations.

k. Tibial Fracture

i. Description/Definition. Fracture of the tibia proximal to the malleoli.

(a). Open tibial fractures are graded in severity according to the Gustilo-Anderson Classification:

(i). Type I: Less than 1 cm (puncture wounds).

(ii). Type II: 1 to 10 cm.

(iii). Type III-A: Greater than 10 cm, sufficient soft tissue preserved to cover the wound (includes gunshot wounds and any injury in a contaminated environment).

(iv). Type III-B: Greater than 10 cm, requiring a soft tissue coverage procedure.

(v). Type III-C: With vascular injury requiring repair.

ii. Occupational Relationship. Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings. May have a short, abnormally rotated extremity. Effusion if the knee joint involved.

iv. Diagnostic Testing Procedures: Radiographs. CT scanning or MRI.

v. Non-operative Treatment Procedures:

(a). Initial Treatment—protected weight-bearing; functional bracing. There is some evidence for use of pneumatic braces with stress fractures.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions, after bony union has been achieved. They should include bracing then range-of-motion (ROM), active therapies including proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, restoring normal joint mechanics, influenced by proximal and distal structures. Therapy should include training on the use of adaptive equipment and home and work site evaluations when appropriate. Bracing may be appropriate. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(g). Orthotics such as heel lifts and custom shoe build-ups may be required when leg-length discrepancy persists.

(h). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(i). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations. Unstable fracture pattern, displaced fracture (especially if the knee joint is involved), open fracture, and non-union.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures. Often closed rodding for shaft fractures. Open reduction and internal fixation more common for fractures involving the knee joint or pilon fractures of the distal tibia.

(a). Human bone morphogenetic protein (RhBMP): this material is used for surgical repair of open tibial fractures. Refer to Therapeutic Procedures, Operative for further specific information.

(b). Stem cell use - stem cells have been added to allograft to increase fracture union. Their use is considered experimental and is not recommended at this time.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Treatment may include protected weight-bearing and active therapy with or without passive therapy for early range of motion if joint involvement.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

I. Trochanteric Fracture

i. Description/Definition: Fracture of the greater trochanter of the proximal femur.

ii. Occupational Relationship. Usually from a traumatic injury such as a fall or crush.

iii. Specific Physical Exam Findings: Local tenderness over the greater trochanter. Sometimes associated swelling, ecchymosis.

iv. Diagnostic Testing Procedures. Radiographs, CT scans or MRI.

v. Non-operative Treatment Procedures:

(a). Initial Treatment: protected weight-bearing.

(b). Medications such as analgesics and anti-inflammatories may be helpful. Refer to medication discussions in Medications and Medical Management.

(c). Patient education should include instruction in self-management techniques, ergonomics, body mechanics, home exercise, joint protection, and weight management.

(d). Refer to comments related to osteoporosis in Therapeutic Procedures, Non-operative, Osteoporosis Management.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

(f). Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions, after bony union has been achieved. They should include

bracing then range-of-motion (ROM), active therapies, and a home exercise program. Active therapies include proprioception training, restoring normal joint mechanics, and clearing dysfunctions from adjacent structures, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM, strength, and normal joint mechanics influenced by proximal and distal structures. Bracing may be appropriate. Refer to Therapeutic Procedures, Non-operative.

(i). Passive modalities are most effective as adjunctive treatments to improve the results of active treatment. They may be used as found as adjunctive in Therapeutic Procedures, Non-operative.

(g). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(h). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

vi. Surgical Indications/Considerations. Large, displaced fragment, open fracture.

(a). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

vii. Operative Procedures: Open reduction, internal fixation.

viii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

(b). Protected weight-bearing is usually needed. Full weight-bearing with radiographic and clinical signs of healing.

(c). Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2311. Therapeutic Procedures—Non-Operative**

A. Treating providers, as well as employers and insurers are highly encouraged to reference the General Guidelines Principles (Section B) prior to initiation of any therapeutic procedure. Before initiation of any therapeutic procedure, the authorized treating provider, employer and insurer must consider these important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified, restricted duty during their rehabilitation at the earliest appropriate time. Refer to Return-to-Work in this section for detailed information.

C. Second, cessation and/or review of treatment modalities should be undertaken when no further significant

subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

D. Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

E. Lastly, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. In cases where a patient is unable to attend an outpatient center, home therapy may be necessary. Home therapy may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone. Home therapy is usually of short duration and continues until the patient is able to tolerate coming to an outpatient center.

G. The following procedures are listed in alphabetical order.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation in the lower extremity. There is some scientific evidence to support its use for hip and knee osteoarthritis. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by licensed practitioners.

a. Acupuncture is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range-of-motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

b. Acupuncture with Electrical Stimulation is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

i. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

c. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

- i. Time to Produce Effect: three to six treatments.
- ii. Frequency: One to three times per week.
- iii. Optimum Duration: One to two months.
- iv. Maximum Duration: 14 treatments.
- v. Any of the above acupuncture treatments may

extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

d. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities and time frames.

2. Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

a. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

b. Indications for biofeedback include individuals who are suffering from musculoskeletal injury in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized along with other treatment modalities.

- i. Time to Produce Effect: Three to four sessions.
- ii. Frequency: One to two times per week.
- iii. Optimum Duration: Five to six sessions.

iv. Maximum Duration: 10 to 12 sessions. Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate functional gains.

### 3. Bone-Growth Stimulators

a. Electrical. Pre-clinical and experimental literature has shown a stimulatory effect of externally applied electrical fields on the proliferation and calcification of osteoblasts and periosteal cells. All of the studies on bone growth stimulators, however, have some methodological deficiencies and high-quality literature of electrical bone growth stimulation is lacking for lower extremity injuries.

i. These acceptable nonsurgical techniques include Capacitive Coupling (CC), which places skin electrodes on opposite sides of the bone being treated and Pulsed Electromagnetic Field (PEMF) which uses a current-carrying coil which induces a secondary electrical field in bone.

ii. There is insufficient evidence to conclude a benefit of electrical stimulation for delayed union, non-union, long bone fracture healing, fresh fractures, or tibial stress fractures.

b. Low-intensity Pulsed Ultrasound: There is some evidence that low-intensity pulsed ultrasound, applied by the patient at home and administered as initial treatment of the fracture, reduces the time required for cortical bridging in tibial fractures. Non-union and delayed unions were not included in these clinical trials. Possible indications for Low-Intensity Pulsed Ultrasound are non-unions or fractures that are expected to require longer healing time.

i. FDA approved bone-growth stimulators of any type may be appropriate for patients with non-union after initial fracture care or for patients with acute fractures or osteotomies who are at high risk for delayed union or non-union. Patients at high risk include, but are not limited to, smokers, diabetics, and those on chemotherapeutic agents or other long-term medication affecting bone growth. Due to lack of supporting scientific evidence, stimulators require prior authorization.

### 4. Extracorporeal Shock Wave Therapy (ESWT)

a. Extracorporeal shock wave therapy (ESWT) delivers an externally applied acoustic pulse to the plantar fascia. It has been hypothesized that ESWT causes microtrauma to the fascia, inducing a repair process involving the formation of new blood vessels and delivery of nutrients to the affected area. High energy ESWT is delivered in one session and may be painful requiring some form of anesthesia. It is not generally recommended for the treatment of plantar heel pain due to increased cost when it is performed with conscious sedation. It may also be performed with local blocks. Low energy ESWT does not require anesthetics. It is given in a series of treatments, generally three sessions.

b. There is conflicting evidence concerning low energy ESWT for plantar heel pain. Focused ESWT concentrates the acoustic pulse on a single point in the heel, while radial ESWT distributes the pulse along the entire plantar fascia. Focused low energy ESWT has not been shown to produce clinically important reductions in plantar heel pain. There is some evidence that radial ESWT may reduce plantar pain more effectively than placebo, but a successful response may occur in only 60 percent of

patients. There is some evidence supporting high-energy ESWT.

c. Low energy radial or high energy ESWT with local blocks are accepted treatments. It should only be used on patients who have had plantar pain for four months or more; have tried NSAIDs, ice, stretching exercises, shoe inserts; and have significant functional deficits. These patients should meet the indications for surgery found in heel spurs, plantar fascia pain. Tarsal tunnel syndrome should be ruled out. Peripheral vascular disease, lower extremity neuropathy and diabetes are all relative contraindications. Diagnostic testing may be needed to rule out these conditions.

i. Time to Effect: Two sessions.

ii. Optimum Duration: Three sessions one week or more apart.

iii. Maximum Duration: Treatment may be continued for up to five total sessions if functional improvement has been demonstrated after three treatment sessions. Functional improvement is preferably demonstrated using direct testing or functional scales validated in clinical research settings.

#### 5. Injections-Therapeutic

a. Description. Therapeutic injection procedures may play a significant role in the treatment of patients with lower extremity pain or pathology. Therapeutic injections involve the delivery of anesthetic and/or anti-inflammatory medications to the painful structure. Therapeutic injections have many potential benefits. Ideally, a therapeutic injection will: reduce inflammation in a specific target area; relieve secondary muscle spasm; allow a break from pain; and support therapy directed to functional recovery. Diagnostic and therapeutic injections should be used early and selectively to establish a diagnosis and support rehabilitation. If injections are overused or used outside the context of a monitored rehabilitation program, they may be of significantly less value.

b. Indications. Diagnostic injections are procedures which may be used to identify pain generators or pathology. For additional specific clinical indications see Specific Lower Extremity Injury Diagnosis, Testing and Treatment.

c. Special Considerations. The use of injections has become progressively sophisticated. Each procedure considered has an inherent risk, and risk versus benefit should be evaluated when considering injection therapy. In addition, all injections must include sterile technique.

d. Contraindications. General contraindications include local or systemic infection, bleeding disorders, allergy to medications used, and patient refusal. Specific contraindications may apply to individual injections.

e. Joint Injections: are generally accepted, well-established procedures that can be performed as analgesic or anti-inflammatory procedures.

i. Time to Produce Effect: Immediate with local anesthesia, or within three days if no anesthesia.

ii. Optimum Duration: Usually one to two injections is adequate.

iii. Maximum Duration: Not more than three to four times annually.

iv. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to

check their blood-glucose level at least twice daily for two weeks post-injections.

f. Soft Tissue Injections: include bursa and tendon insertions. Injections under significant pressure should be avoided as the needle may be penetrating the tendon. Injection into the tendon can cause tendon degeneration, tendon breakdown, or rupture. Injections should be minimized for patients under 30 years of age.

i. When performing tendon insertion injections, the risk of tendon rupture should be discussed with the patient and the need for restricted duty emphasized.

(a). Time to Produce Effect: Immediate with local anesthesia, or within three days if no anesthesia.

(b). Optimum Duration: Usually one to two injections is adequate.

(c). Maximum Duration: Not more than three to four times annually.

ii. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood-glucose level at least twice daily for two weeks post-injections.

g. Trigger Point Injections: although generally accepted, have only rare indications in the treatment of lower extremity disorders. Therefore, the OWCA does not recommend their routine use in the treatment of lower extremity injuries.

i. Description. Trigger point treatment can consist of dry needling or injection of local anesthetic with or without corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

ii. There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

iii. Indications. Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue with a therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems, and any abnormalities need to be ruled out prior to injection.

iv. Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local

autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a six week time frame.

v. Complications. Potential but rare complications of trigger point injections include infection, anaphylaxis, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of developing local myopathy. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

(a). Time to Produce Effect: Local anesthetic 30 minutes; no anesthesia 24 to 48 hours.

(b). Frequency: Weekly, suggest no more than four injection sites per session per week to avoid significant post-injection soreness.

(c). Optimum Duration: Four Weeks.

(d). Maximum Duration: Eight weeks.

Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

h. Viscosupplementation/Intracapsular Acid Salts: is an accepted form of treatment for osteoarthritis or degenerative changes in the knee joint. There is good evidence that intra-articular hyaluronic acid injections have only a small effect on knee pain and function. Therefore, the patient and treating physician should identify functional goals and the likelihood of achieving improved ability to perform activities of daily living or work activities with injections versus other treatments. The patient should agree to comply with the treatment plan including home exercise. These injections may be considered an alternative in patients who have failed non-operative treatment and surgery is not an option, particularly, if non-steroidal anti-inflammatory drug treatment is contraindicated or has been unsuccessful. Viscosupplementation is not recommended for patients with severe osteoarthritis who are surgical candidates. Its efficacy beyond six months is not well-established. There is no evidence that one product significantly outperforms another, prior authorization is required to approve product choice and for repeat series of injections.

i. One injection of 6 ml of Hylan G-F 20 may be effective and is an option for knee injections.

ii. Viscosupplementation is not recommended for ankle osteoarthritis due to the small effect size documented in knee conditions and the lack of evidence supporting its use in the ankle. Viscosupplementation is not recommended for hip arthritis given the probable superiority of corticosteroid injections. In rare cases a patient with significant hip osteoarthritis who does not qualify for surgical intervention may try viscosupplementation. It should be done with ultrasound or fluoroscopic guidance and will not necessarily require a series of three injections. The patient may choose to have repeat injections when the first injection was successful.

(a). Time to Produce Effect: After one series or one injection as discussed above, there must be a functional gain lasting three months to justify repeat injections.

(b). Frequency: One injection or one series (three to five injections generally spaced one week apart).

(c). Optimum/Maximum Duration: Varies. Efficacy beyond six months is not well-established.

i. Prolotherapy (also known as sclerotherapy) consists of peri-articular injections of hypertonic dextrose with or without phenol with the goal of inducing an inflammatory response that will recruit cytokine growth factors involved in the proliferation of connective tissue. Advocates of prolotherapy propose that these injections will alleviate complaints related to joint laxity by promoting the growth of connective tissue and stabilizing the involved joint.

i. Laboratory studies may lend some biological plausibility to claims of connective tissue growth, but high quality published clinical studies are lacking. The dependence of the therapeutic effect on the inflammatory response is poorly defined, raising concerns about the use of conventional anti-inflammatory drugs when proliferant injections are given. The evidence in support of prolotherapy is insufficient and therefore, its use is not recommended in lower extremity injuries.

6. Jobsite Alteration. Early evaluation and training of body mechanics are essential for every injured worker. Risk factors to be addressed include: repetitive work, lifting, and forces that have an impact on the lower extremity. In some cases, this requires a jobsite evaluation. There is no single factor or combination of factors that is proven to prevent or ameliorate lower extremity pain, but a combination of ergonomic and psychosocial factors are generally considered to be important. Physical factors that may be considered include use of force, repetitive work, squatting, climbing, kneeling, crouching, crawling, prolonged standing, walking a distance or on uneven surfaces, jumping, running, awkward positions requiring use of force, and lower extremity vibration. Psychosocial factors to be considered include pacing, degree of control over job duties, perception of job stress, and supervisory support.

a. The job analysis and modification should include input from the employee, employer, and a medical professional familiar with work place evaluation. An ergonomist may also provide useful information. The employee must be observed performing all job functions in order for the jobsite analysis to be valid. Periodic follow-up is recommended to evaluate effectiveness of the intervention and need for additional ergonomic changes.

i. Ergonomic Changes may be made to modify the hazards identified. In addition, workers should be counseled to vary tasks throughout the day. When possible, employees performing repetitive tasks should take 15 to 30 second breaks every 10 to 20 minutes, or 5-minute breaks every hour. Mini-breaks should include stretching exercises.

ii. Interventions should consider engineering controls (e.g., mechanizing the task, changing the tool used, or adjusting the jobsite), or administrative controls (e.g., adjusting the time an individual performs the task).

7. Medications and medical management. Use of medications will vary widely due to the spectrum of injuries from simple strains to complicated fractures. A thorough medication history, including use of alternative and over-the-counter medications, should be performed at the time of the initial visit and updated periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter

medications as well as the contents of over-the-counter herbal products.

a. Nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen are useful in the treatment of injuries associated with degenerative joint disease and/or inflammation. These same medications can be used for pain control.

b. Topical agents can be beneficial for pain management in lower extremity injuries. This includes topical capsaicin, nonsteroidals, as well as topical iontophoresis/phonophoresis, such as steroid creams and lidocaine.

c. Glucosamine and chondroitin are sold in the United States as dietary supplements. Their dosage, manufacture, and purity are not regulated by the Food and Drug Administration. For moderate to severe knee osteoarthritis, there is good evidence for the effectiveness of a pharmaceutical grade combination of 500 mg glucosamine hydrochloride and 400 mg chondroitin sulfate three times per day. Effectiveness for mild disease is unknown. Recent literature suggests that chondroitin sulfate in a dose of 800 mg once daily may reduce the rate of joint degradation as demonstrated by joint space loss on serial x-rays.

d. For mild-to-moderate osteoarthritis confined to the hip, there is good evidence that a pharmaceutical-grade glucosamine sulfate is unlikely to produce a clinically significant improvement in pain and joint function.

e. When osteoarthritis is identified as a contributing factor to a work-related injury, pharmaceutical grade glucosamine and chondroitin may be tried. Long-term coverage for these medications would fall under Workers' Compensation only when the arthritic condition is primarily related to the work injury.

f. S-adenosyl methionine (SAM-e), like glucosamine and chondroitin, is sold as a dietary supplement in the United States, with a similar lack of standard preparations of dose and manufacture. There is some evidence that a pharmaceutical-grade SAM-e is as effective as celecoxib in improving pain and function in knee osteoarthritis, but its onset of action is slower. Studies using liquid chromatography have shown that it may lose its potency after several weeks of storage. In addition, SAM-e has multiple additional systemic effects. It is not currently recommended due to lack of availability of pharmaceutical quality, systemic effects, and loss of potency with storage.

i. The following are listed in alphabetical order.

(a). Acetaminophen: is an effective analgesic with antipyretic but not anti-inflammatory activity. Acetaminophen is generally well tolerated, causes little or no gastrointestinal irritation and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations may contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed 2250 mg per 24 hour period, from all sources, including narcotic-acetaminophen combination preparations.

(i). Optimal Duration: 7 to 10 days.

(ii). Maximum Duration: Chronic use as indicated on a case-by-case basis. Use of this substance long-term for three days per week or greater may be associated with rebound pain upon cessation.

b. Bisphosphonates may be used for those qualifying under osteoporosis guidelines. Long-term use for the purpose of increasing prosthetic fixation is not recommended as long-term improvement in fixation is not expected. See Osteoporosis Management Section below.

c. Deep Venous Thrombosis Prophylaxis is a complex issue involving many variables such as individual patient characteristics, the type of surgery, anesthesia used and agent(s) used for prophylaxis. Final decisions regarding prophylaxis will depend on the surgeon's clinical judgment. The following are provided as generally accepted concepts regarding prophylaxis at the time of writing of these guidelines.

i. All patients undergoing lower extremity surgery or prolonged lower extremity immobilization should be evaluated for elevated risk for DVT and should receive education on prevention. Possible symptoms should be discussed. Patients at higher risk than the normal population include, but are not limited to, those with known hypercoagulable states and those with previous pulmonary embolism or DVT. Those considered at higher risk for bleeding, which may alter thromboprophylaxis protocols, include patients with a history of a bleeding disorder, recent gastrointestinal bleed, or hemorrhagic stroke.

ii. There is no evidence to support mandatory prophylaxis for all patients who are immobilized or undergo lower extremity procedures, outside of hip or knee arthroplasties or hip fracture repair.

iii. Hip and knee arthroplasties and hip fracture repair are standard risk factors requiring thromboprophylaxis. Commonly used agents are low molecular weight heparin, low dose unfractionated heparin (LDUH), synthetic pentasaccharide fondaparinux, or warfarin. If aspirin is used, it should be accompanied by aggressive mechanical prophylaxis.

iv. All patients should be mobilized as soon as possible after surgery. Mechanical prophylaxis such as pneumatic devices that are thigh calf, calf only, or foot pumps may be considered immediately post-operatively and/or until the patient is discharged home. Thigh length or knee high graduated compression stockings are used for most patients. With prolonged prophylaxis, lab tests must be drawn regularly. These may be accomplished with home health care or outpatient laboratories when appropriate.

d. Minor Tranquilizer/Muscle Relaxants are appropriate for muscle spasm, mild pain and sleep disorders. When prescribing these agents, physicians must seriously consider side effects of drowsiness or dizziness and the fact that benzodiazepines may be habit-forming.

i. Optimal Duration: One week.

ii. Maximum Duration: Four weeks.

e. Narcotics: should be primarily reserved for the treatment of severe lower extremity pain. There are circumstances where prolonged use of narcotics is justified based upon specific diagnosis, and in these cases, it should be documented and justified. In mild-to-moderate cases of lower extremity pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

i. Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with

definitive cessation parameters. Pain is subjective in nature and should be evaluated using a pain scale and assessment of function to rate effectiveness of the narcotic prescribed. Any use beyond the maximum duration should be documented and justified based on the diagnosis and/or invasive procedures.

(a). Optimal Duration: Three to seven days.

(b). Maximum Duration: Two weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management. When prescribing beyond the maximum duration, it is recommended physicians access the Colorado PDMP (Prescription Drug Monitoring Program). This system allows the prescribing physician to see all controlled substances prescribed by other physicians for an individual patient.

f. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advise that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, histamine 2 blockers, or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete Blood Count (CBC) and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

i. NSAIDs may be used for pain management after joint replacement. They have also been used to reduce heterotopic ossification after arthroplasty. NSAIDs do reduce the radiographically documented heterotopic ossification in this setting, but there is some evidence that they do not improve functional outcomes and they may increase the risk of bleeding events in the post-operative period. Their routine use for prevention of heterotopic bone formation is not recommended.

(a). Non-Selective Nonsteroidal Anti-Inflammatory Drugs: Includes NSAIDs and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal

toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

i. Optimal Duration: One week.

ii. Maximum Duration: One year. Use of these substances long-term (Three days per week or greater) is associated with rebound pain upon cessation.

b. Selective Cyclo-oxygenase-2 (COX-2) Inhibitors:

i. COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency, thus renal function may need monitoring.

ii. COX-2 inhibitors should not be first-line for low risk patients who will be using a NSAID short-term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

(a). Optimal Duration: 7 to 10 days.

(b). Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (Three days per week or greater) is associated with rebound pain upon cessation.

g. Oral Steroids: have limited use but are accepted in cases requiring potent anti-inflammatory drug effect in carefully selected patients. A one-week regime of steroids may be considered in the treatment of patients who have arthritic flare-ups with significant inflammation of the joint. The physician must be fully aware of potential contraindications for the use of all steroids such as hypertension, diabetes, glaucoma, peptic ulcer disease, etc., which should be discussed with the patient.

i. Optimal Duration: Three to seven days.

ii. Maximum Duration: Seven days.

h. Osteoporosis Management. All patients with conditions which require bone healing, especially those over 50, should be encouraged to ingest at least 1200 mg of Calcium and 800 IU of Vitamin D per day. There is some evidence that, for women in the older age group (58 to 88) with low hip bone density, greater callus forms for those who adhere to these recommendations than those who do not. Although the clinical implications of this are not known, there is greater non-union in this age group and thus, coverage for these medications during the fracture healing time period is recommended. At this time there is no evidence that bisphosphonates increase acute fracture healing.

i. Female patients over 65 should be referred for an osteoporosis evaluation if one has not been completed the previous year. Patients who have been on prednisone at a dose of 5 to 7.5 mg for more than 3 months should be evaluated for glucocorticoid induced osteoporosis. An osteoporosis evaluation may be considered for males who: are over 70, are physically inactive, have previous fragility

fracture, have a BMI less than 20, or have been hypogonadal for 5 years. Evaluation may also be considered for patients on medications that can cause bone loss, patients who have suffered a fracture due to a low-impact fall or with minimum to no provocation, and women under 65 with one of the following: menopause before 40, current smoker, or body mass index less than 20. Low body weight appears to be the best predictor of osteoporosis in women younger than 65. In one adequate study, all patients aged 50 to 75 referred to an orthopaedic department for treatment of wrist, vertebral, proximal humerus, or hip fractures received bone mass density testing. 97 percent of patients had either osteoporosis (45 percent) or osteopenia (42 percent). Referral is important to prevent future fractures in these groups. Long-term care for osteoporosis is not covered under workers compensation even though it may be discovered due to an injury-related acute fracture.

i. Psychotropic/Anti-anxiety/Hypnotic Agents may be useful for treatment of mild and chronic pain, dysesthesias, sleep disorders, and depression. Post-operative patients may receive medication to assure normal sleep cycles. Antidepressant medications, such as tricyclics and Selective Serotonin Reuptake Inhibitors (SSRIs), are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low dose, are useful for chronic pain but have more frequent side effects.

i. Anti-anxiety medications are best used for short-term treatment (i.e., less than six months). Accompanying sleep disorders are best treated with sedating antidepressants prior to bedtime. Frequently, combinations of the above agents are useful. As a general rule, physicians should access the patient's prior history of substance abuse or depression prior to prescribing any of these agents.

ii. Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not routinely recommended. Refer to the Chronic Pain Guidelines which give a detailed discussion regarding medication use in chronic pain management.

(a). Optimal Duration: One to six months.

(b). Maximum Duration: 6 to 12 months, with monitoring.

j. Topical Drug Delivery: Creams and patches may be an alternative treatment of localized musculoskeletal disorders. It is necessary that all topical agents be used with strict instructions for application as well as the maximum number of applications per day to obtain the desired benefit and avoid potential toxicity. As with all medications, patient selection must be rigorous to select those patients with the highest probability of compliance. Refer to "Iontophoresis" in the Passive Therapy of this section for information regarding topical iontophoretic agents.

i. Topical Salicylates and Nonsalicylates: have been shown to be effective in relieving pain in acute and chronic musculoskeletal conditions. Topical salicylate and nonsalicylates achieve tissue levels that are potentially therapeutic, at least with regard to COX inhibition. Other than local skin reactions, the side effects of therapy are minimal, although not non-existent, and the usual contraindications to use of these compounds needs to be considered. Local skin reactions are rare and systemic effects were even less common. Their use in patients receiving warfarin therapy may result in alterations in

bleeding time. Overall, the low level of systemic absorption can be advantageous; allowing the topical use of these medications when systemic administration is relatively contraindicated such as is the case in patients with hypertension, cardiac failure, or renal insufficiency.

(a). There is no evidence that topical agents are more or less effective than oral medications.

(i). Optimal Duration: One week.

(ii). Maximal Duration: Two weeks per episode.

ii. Capsaicin: is another medication option for topical drug use in lower extremity injury. Capsaicin offers a safe and effective alternative to systemic NSAID therapy. Although it is quite safe, effective use of capsaicin is limited by the local stinging or burning sensation that typically dissipates with regular use, usually after the first 7 to 10 days of treatment. Patients should be advised to apply the cream on the affected area with a plastic glove or cotton applicator and to avoid inadvertent contact with eyes and mucous membranes.

(a). Optimal Duration: One week.

(b). Maximal Duration: Two weeks per episode.

iii. Iontophoretic Agents: Refer to "Iontophoresis," under Passive Therapy of this section.

k. Tramadol is useful in relief of lower extremity pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Tramadol is an atypical opioid with norepinephrine and serotonin reuptake inhibition. It is not considered a controlled substance in the U.S. Although Tramadol may cause impaired alertness, it is generally well tolerated, does not cause gastrointestinal ulceration, or exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as MAO inhibitors, SSRIs, and tricyclic antidepressants. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation and is not recommended for patients with prior opioid addiction.

i. Optimal Duration: Three to seven days.

ii. Maximum Duration: Two weeks. Use beyond two weeks is acceptable in appropriate cases.

## 8. Occupational Rehabilitation Programs

a. Interdisciplinary: programs are well-established treatment for patients with sub-acute and functionally impairing cervical spine pain. They are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured workers program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. Programs should include cognitive-behavioral therapy as there is good evidence for its effectiveness in patients with chronic low back pain and it is probably effective in cervical spine pain. These programs are for patients with greater levels of disability, dysfunction, deconditioning and psychological involvement. For patients with chronic pain, refer to the Chronic Pain Disorder Medical Treatment Guidelines.

i. Work Hardening

(a). Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

(b). This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; occupational therapy; physical therapy; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, vocational specialist or Certified Biofeedback Therapist.

- (i). Length of Visit: up to eight hours/day
- (ii). Frequency: Two to five visits per week
- (iii). Optimal Duration: Two to four weeks
- (iv). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

b. Non-Interdisciplinary. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work. The service may include the time-limited use of passive modalities with progression to achieve treatment and/or simulated/real work.

i. Work Conditioning. These programs are usually initiated once reconditioning has been completed but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified- or full-duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

- (a). Length of visit: One to two hours per day.
- (b). Frequency: Two to five visits per week.
- (c). Optimum Duration: Two to four weeks.
- (d). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return-to-work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

- (a). Length of visit: two to six hours per day.
- (b). Frequency: two to five visits per week.
- (c). Optimum Duration: two to four weeks.

(d). Maximum Duration: Six weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

#### 9. Orthotics and prosthetics

a. Fabrication/Modification of Orthotics: would be used when there is need to normalize weight-bearing, facilitate better motion response, stabilize a joint with insufficient muscle or proprioceptive/reflex competencies, to protect subacute conditions as needed during movement, and correct biomechanical problems. Footwear modifications may be necessary for work shoes and everyday shoes. Replacement is needed every six months to one year. For specific types of orthotics/prosthetics see Section e, "Specific Lower Extremity Injury Diagnosis, Testing and Treatment."

- i. Time to Produce Effect: One to three sessions (includes wearing schedule and evaluation).
- ii. Frequency: One to two times per week.
- iii. Optimum/Maximum Duration: Over a period of approximately four to six weeks for casting, fitting, and re-evaluation.

b. Orthotic/Prosthetic Training: is the skilled instruction (by qualified providers) in the proper use of orthotic devices and/or prosthetic limbs including stump preparation, donning and doffing limbs, instruction in wearing schedule and orthotic/prosthetic maintenance training. Training can include gait, mobility, transfer and self-care techniques.

- i. Time to Produce Effect: Two to six sessions.
- ii. Frequency: Three times per week.
- iii. Optimum/Maximum Duration: two to four months.

c. Splints or Adaptive Equipment—design, fabrication and/or modification indications include the need to control neurological and orthopedic injuries for reduced stress during functional activities and modify tasks through instruction in the use of a device or physical modification of a device, which reduces stress on the injury. Equipment should improve safety and reduce risk of re-injury. This includes high and low technology assistive options such as workplace modifications, crutch or walker training, and self-care aids.

- i. Time to Produce Effect: Immediate.
- ii. Frequency: One to three sessions or as indicated to establish independent use.
- iii. Optimum/Maximum Duration: One to three sessions.

10. Patient Education. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed.

- a. Time to Produce Effect: Varies with individual patient.
- b. Frequency: Should occur at each visit.

11. Personality/psychosocial/psychiatric/psychological intervention. Psychosocial treatment is a generally accepted, widely used and well-established intervention. This group of therapeutic and diagnostic modalities includes, but is not limited to: individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis and meditation. Any screening or diagnostic workup should clarify and distinguish between pre-existing versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. This can be used alone or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

- a. Time to Produce Effect: Two to four weeks.
- b. Frequency: One to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly.
- c. Optimum Duration: Six weeks to three months.
- d. Maximum Duration: 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required, and if further counseling beyond three months is indicated, documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every four to six weeks during treatment.

12. Restriction of activities varies according to the specific diagnosis and the severity of the condition. Job modification/modified duty are frequently required to avoid exacerbation of the injured lower extremity. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with lower extremity injuries.

13. Return-to-Work. Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months. It is imperative that the patient be educated regarding the benefits of return-to-work, work restrictions, and follow-up if problems arise. When attempting to return a patient to work after a specific injury, clear objective restrictions of activity level should be made. An accurate job description with detailed physical duty restrictions is often necessary to assist the physician in making return-to-work recommendations. This may require a jobsite evaluation.

a. Employers should be prepared to offer transitional work. This may consist of temporary work in a less demanding position, return to the regular job with restrictions, or gradual return to the regular job. Company policies which encourage return-to-work with positive communication are most likely to have decreased worker disability.

b. Return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Due to the large spectrum of injuries

of varying severity and varying physical demands in the work place, it is not possible to make specific return-to-work guidelines for each injury. Therefore, the OWCA recommends the following:

c. Compliance with Activity Restrictions: In some cases, compliance with restriction of activity levels may require a complete jobsite evaluation, a functional capacity evaluation (FCE), or other special testing. Refer to the "Special Tests" section of these guidelines.

d. Establishment of a Return-to-Work Status: Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan, and addressed at every visit. A description of daily activity limitations is part of any treatment plan and should be the basis for restriction of work activities. In most cases non-surgical the patient should be able to return to work in some capacity or in an alternate position consistent with medical treatment within several days unless there are extenuating circumstances. Injuries requiring more than two weeks off work should be thoroughly documented (Some of these diagnoses are listed in Specific Lower Extremity Injury Diagnosis, Testing and Treatment).

e. Establishment of Activity Level Restrictions: Communication is essential between the patient, employer and provider to determine appropriate restrictions and return-to-work dates. It is the responsibility of the physician to provide clear concise restrictions, and it the employer's responsibility to determine if temporary duties can be provided within the restrictions. For lower extremity injuries, the following should be addressed when describing the patient's activity level:

- i. lower body postures such as squatting, kneeling, crawling, stooping, or climbing, including duration and frequency;
- ii. ambulatory level for distance, frequency and terrain;
- iii. static and dynamic standing including duration and frequency;
- iv. ability to maintain balance;
- v. use of adaptive devices, including cane and walker, to accomplish basic job duties.

14. Therapy-Active. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. They are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range-of-motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

a. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

i. The following active therapies are listed in alphabetical order:

(a). Activities of Daily Living (ADL) are well-established interventions which involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

(i). Time to Produce Effect: Four to five treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

(b). Aquatic Therapy is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote ROM, flexibility, core stabilization, endurance, strengthening, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely to have a successful trial of therapeutic exercise. Studies have shown that the muscle recruitment for aquatic therapy versus similar non-aquatic motions is significantly less. Because there is always a risk of recurrent or additional damage to the muscle tendon unit after a surgical repair, aquatic therapy may be preferred by surgeons to gain early return of ROM. In some cases the patient will be able to do the exercises unsupervised after the initial supervised session. Parks and recreation contacts may be used to locate less expensive facilities for patients. Indications include:

(i). Post-operative therapy as ordered by the surgeon; or

(ii). Intolerance for active land-based or full-weight-bearing therapeutic procedures; or

(iii). Symptoms that are exacerbated in a dry environment; and

(iv). Willingness to follow through with the therapy on a regular basis.

(v). The pool should be large enough to allow full extremity ROM and fully erect posture. Aquatic vests, belts, snorkels, and other devices may be used to provide stability, balance, buoyancy, and resistance.

[a]. Time to Produce Effect: Four to five treatments.

[b]. Frequency: Three to five times per week.

[c]. Optimum Duration: Four to six weeks.

[d]. Maximum Duration: Eight weeks.

(vi). A self-directed program is recommended after the supervised aquatics program has been established, or alternatively a transition to a self-directed dry environment exercise program.

(vii). There is some evidence that for osteoarthritis of the hip or knee, aquatic exercise probably slightly reduces pain and slightly improves function over three months.

(c.) Functional Activities are the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(i). Time to Produce Effect: Four to five treatments

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks

(d). Functional Electrical Stimulation is the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. Indications include muscle atrophy, weakness, sluggish muscle contraction, neuromuscular dysfunction or peripheral nerve lesion. Indications also may include an individual who is precluded from active therapy.

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Eight weeks.

(iv). Maximum Duration: Eight weeks. If beneficial, provide with home unit. Home use is not recommended for neuromuscularly intact patients.

(e). Gait Training is crutch walking, cane or walker instruction to a person with lower extremity injury or surgery. Indications include the need to promote normal gait pattern with assistive devices; instruct in the safety and proper use of assistive devices; instruct in progressive use of more independent devices (i.e., platform-walker, to walker, to crutches, to cane); instruct in gait on uneven surfaces and steps (with and without railings) to reduce risk of fall, or loss of balance; and/or instruct in equipment to limit weight-bearing for the protection of a healing injury or surgery.

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Two weeks.

(iv). Maximum Duration: Two weeks.

(f). Neuromuscular Re-education: is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception; kinesthetic sense; coordination; education of movement, balance and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Eight weeks.

(g). Therapeutic Exercise is a generally accepted treatment with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. There is good evidence to support the functional benefits of manual therapy with

exercise, walking programs, conditioning, and other combined therapy programs. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, increased range of motion and are used to promote normal movement patterns. May also include complementary/alternative exercise movement therapy.

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Eight weeks.

(h). Wheelchair Management and Propulsion is the instruction and training of self-propulsion and proper use of a wheelchair. This includes transferring and safety instruction. This is indicated in individuals who are not able to ambulate due to bilateral lower extremity injuries, inability to use ambulatory assistive devices, and in cases of multiple traumas.

(i). Time to Produce Effect: Two to six treatments.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Two weeks.

(iv). Maximum Duration: Two weeks.

15. Therapy-passive. Most of the following passive therapies and modalities are generally well-accepted methods of care for a variety of work-related injuries. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be use adjunctively with active therapies to help control swelling, pain, and inflammation during the rehabilitation process. They may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" has been completed alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

i. The following passive therapies and modalities are listed in alphabetical order.

(a). Continuous Passive Motion (CPM) is a form of passive motion using specialized machinery that acts to move a joint and may also pump blood and edema fluid away from the joint and periarticular tissues. CPM is effective in preventing the development of joint stiffness if

applied immediately following surgery. It should be continued until the swelling that limits motion of the joint no longer develops. ROM for the joint begins at the level of patient tolerance and is increased twice a day as tolerated. Home use of CPM is expected after chondral defect surgery. CPM may be necessary for cases with ACL repair, manipulation, joint replacement or other knee surgery if the patient has been non compliant with pre-operative ROM exercises. Use of this equipment may require home visits.

(i). Time to Produce Effect: Immediate.

(ii). Frequency: Up to four times a day.

(iii). Optimum Duration: Up to three weeks post surgical.

(iv). Maximum Duration: Three weeks.

(b). Contrast Baths can be used for alternating immersion of extremities in hot and cold water. Indications include edema in the sub-acute stage of healing, the need to improve peripheral circulation and decrease joint pain and stiffness.

(i). Time to Produce Effect: Three treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four weeks.

(iv). Maximum Duration: One month.

(c). Electrical Stimulation (Unattended): once applied, requires minimal on-site supervision by the physician or non-physician provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation.

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Varies, depending upon indication, between two to three times per day to one time a week. Provide home unit if treatment is effective and frequent use is recommended.

(iii). Optimum Duration: One to three months.

(iv). Maximum Duration: Three months.

(d). Fluidotherapy: employs a stream of dry, heated air that passes over the injured body part. The injured body part can be exercised during the application of dry heat. Indications include the need to enhance collagen extensibility before stretching, reduce muscle guarding, or reduce inflammatory response.

(i). Time to Produce Effect: One to four treatments.

(ii). Frequency: One to three times per week.

(iii). Optimum Duration: Four weeks.

(iv). Maximum Duration: One month.

(e). Hyperbaric Oxygen Therapy. There is no evidence to support long-term benefit of hyperbaric oxygen therapy for non-union lower extremity fractures. It is not recommended.

(f). Infrared Therapy is a radiant form of heat application. Indications include the need to elevate the pain threshold before exercise and to alleviate muscle spasm to promote increased movement.

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Three weeks as primary, or up to two months if used intermittently as an adjunct to other therapeutic procedures.

(iv). Maximum Duration: Two months.

(g). Iontophoresis: is the transfer of medication, including, but not limited to, steroidal anti-inflammatory and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, and salicylate), ischemia (magnesium, mecholy, and iodine), muscle spasm (magnesium, calcium); calcific deposits (acetate), scars, and keloids (chlorine, iodine, acetate).

(i). Time to Produce Effect: One to four treatments.

(ii). Frequency: 3 times per week with at least 48 hours between treatments.

(iii). Optimum Duration: 8 to 10 treatments.

(iv). Maximum Duration: 10 treatments.

(h). Manipulation: is a generally accepted, well-established and widely used therapeutic intervention for lower extremity injuries. Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(i). High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment. This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as a) direct a forceful engagement of a restrictive/pathologic barrier, b) indirect a gentle/non-forceful disengagement of a restrictive/pathologic barrier, c) the patient actively assists in the treatment and d) the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

[a]. Time to Produce Effect (for all types of manipulative treatment): One to six treatments.

[b]. Frequency: Up to three times per week for the first three weeks as indicated by the severity of involvement and the desired effect.

[c]. Optimum Duration: 10 treatments.

[d]. Maximum Duration: 12 treatments.

Additional visits may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co-morbidities. Functional gains including increased ROM must be demonstrated to justify continuing treatment.

(i). Manual Electrical Stimulation is used for peripheral nerve injuries or pain reduction that requires

continuous application, supervision, or involves extensive teaching. Indications include muscle spasm (including TENS), atrophy, decreased circulation, osteogenic stimulation, inflammation, and the need to facilitate muscle hypertrophy, muscle strengthening, muscle responsiveness in Spinal Cord Injury/Brain Injury (SCI/BI), and peripheral neuropathies.

(i). Time to Produce Effect: Variable, depending upon use.

(ii). Frequency: Three to seven times per week.

(iii). Optimum Duration: Eight weeks.

(iv). Maximum Duration: Two months.

(j). Massage. Manual or Mechanical: Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by, or with, the practitioners' hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation, and flexibility prior to exercise. In cases with edema, deep vein thrombosis should be ruled out prior to treatment.

(i). Time to Produce Effect: Immediate.

(ii). Frequency: One to two times per week.

(iii). Optimum Duration: Six weeks.

(iv). Maximum Duration: Two months.

(k). Mobilization (Joint). Mobilization is passive movement, which may include passive range of motion performed in such a manner (particularly in relation to the speed of the movement) that it is, at all times, within the ability of the patient to prevent the movement if they so choose. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement.

(i). Time to Produce Effect: Six to nine treatments.

(ii). Frequency: three times per week.

(iii). Optimum Duration: Six weeks.

(iv). Maximum Duration: Two months.

(l). Mobilization (Soft Tissue) is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

(i). Time to Produce Effect: Two to three weeks.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: Four to six weeks.

(iv). Maximum Duration: Six weeks.

(m). Paraffin Bath is a superficial heating modality that uses melted paraffin (candle wax) to treat irregular surfaces such as the foot or ankle. Indications include the need to enhance collagen extensibility before stretching, reduce muscle guarding, or reduce inflammatory response.

(i). Time to Produce Effect: One to four treatments.

(ii). Frequency: One to three times per week.

(iii). Optimum Duration: Four weeks.

(iv). Maximum Duration: One month. If beneficial, provide with home unit or purchase if effective.

(n). Superficial Heat and Cold Therapy: Superficial heat and cold therapies are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It may be used acutely with compression and elevation. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm and promote stretching/flexibility. It includes portable cryotherapy units and application of heat just above the surface of the skin at acupuncture points.

(i). Time to Produce Effect: Immediate.

(ii). Frequency: Two to five times per week.

(iii). Optimum Duration: Three weeks as primary, or up to two months if used intermittently as an adjunct to other therapeutic procedures.

(iv). Maximum Duration: Two months.

(o). Short-Wave Diathermy involves the use of equipment that exposes soft tissue to a magnetic or electrical field. Indications include enhanced collagen extensibility before stretching, reduced muscle guarding, reduced inflammatory response, and enhanced re-absorption of hemorrhage, hematoma, or edema.

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Two to three times per week up to three weeks.

(iii). Optimum Duration: Three to five weeks.

(iv). Maximum Duration: 5 weeks.

(p). Traction. Manual traction is an integral part of manual manipulation or joint mobilization. Indications include decreased joint space, muscle spasm around joints, and the need for increased synovial nutrition and response.

(i). Time to Produce Effect: One to three sessions.

(ii). Frequency: Two to three times per week.

(iii). Optimum Duration: 30 days.

(iv). Maximum Duration: One month.

(q). Transcutaneous Electrical Nerve Stimulation (TENS) is a generally accepted treatment. TENS should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable

functional improvement must be documented prior to the purchase of a home unit.

(i). Time to Produce Effect: Immediate.

(ii). Frequency: Variable.

(iii). Optimum Duration: Three sessions.

(iv). Maximum Duration: Three sessions. If beneficial, provide with home unit or purchase if effective. Due to variations in costs and in models, prior authorization for home units is required.

(r). Ultrasound is an accepted treatment which includes ultrasound with electrical stimulation and Phonophoresis. Ultrasound uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing.

(i). Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves a dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation, and muscle facilitation.

(ii). Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

[a]. Time to Produce Effect: 6 to 15 treatments.

[b]. Frequency: Three times per week.

[c]. Optimum Duration: Four to eight weeks.

[d]. Maximum Duration: Two months.

(s). Vasopneumatic Devices are mechanical compressive devices used in both inpatient and outpatient settings to reduce various types of edema. Indications include pitting edema, lymphedema and venostasis. Maximum compression should not exceed minimal diastolic blood pressure. Use of a unit at home should be considered if expected treatment is greater than two weeks.

(i). Time to Produce Effect: One to three treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: One month.

(iv). Maximum Duration: One month. If beneficial, provide with home unit.

(t). Whirlpool/Hubbard tank is conductive exposure to water at temperatures that best elicits the desired effect (cold vs. heat). It generally includes massage by water propelled by a turbine or Jacuzzi jet system and has the same thermal effects as hot packs if higher than tissue temperature. It has the same thermal effects as cold application if comparable temperature water used. Indications include the need for analgesia, relaxing muscle spasm, reducing joint stiffness, enhancing mechanical debridement and facilitating and preparing for exercise.

(i). Time to Produce Effect: Two to four treatments.

(ii). Frequency: Three to five times per week.

(iii). Optimum Duration: Three weeks as primary, or up to two months if used intermittently as an adjunct to other therapeutic procedures.

(iv). Maximum Duration: Two months.

16. Vocational rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification of highest functional level, motivation and achievement of maximum medical improvement (MMI). Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation. The effectiveness of vocational rehabilitation may be enhanced when performed in combination with work hardening or work conditioning.

a. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression, and promote optimum rehabilitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2313. Therapeutic Procedures—Operative**

A. All operative interventions must be based upon positive correlation of clinical findings, clinical course and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, complex regional pain syndrome or sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention.

B. In addition, operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuromusculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.

C. Structured rehabilitation interventions are necessary for all of the following procedures except in some cases of hardware removal.

D. Return-to-work restrictions should be specific according to the recommendation in the Therapeutic Procedures, Non-Operative.

#### 1. Ankle and Subtalar Fusion

a. Description/Definition: Surgical fusion of the ankle or subtalar joint.

b. Occupational Relationship: Usually post-traumatic arthritis or residual deformity.

c. Specific Physical Exam Findings: Painful, limited range of motion of the joint(s). Possible fixed deformity.

d. Diagnostic Testing Procedures: Radiographs. Diagnostic injections, MRI, CT scan, and/or bone scan.

e. Surgical Indications/Considerations: All reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. Patient has disabling pain or

deformity. Fusion is the procedure of choice for individuals with osteoarthritis who plan to return to physically demanding activities.

i. Prior to surgical intervention, the patient and treating physician should identify functional operative goals, and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

ii. Because smokers have a higher risk of delayed bone healing and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures. Open reduction internal fixation (ORIF) with possible bone grafting. External fixation may be used in some cases.

#### g. Post-Operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

ii. When boney union is achieved, treatment usually includes active therapy with or without passive therapy, including gait training and ADLs.

iii. Rocker bottom soles or shoe lifts may be required. A cast is usually in place for six to eight weeks followed by graduated weight-bearing. Modified duty may last up to four to six months.

iv. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

### 2. Knee Fusion

a. Description/Definition: Surgical fusion of femur to the tibia at the knee joint.

b. Occupational Relationship: Usually from post-traumatic arthritis or deformity.

c. Specific Physical Exam Findings: Stiff, painful, sometime deformed limb at the knee joint.

d. Diagnostic Testing Procedures: Radiographs. MRI, CT, diagnostic injections or bone scan.

e. Surgical Indications/Considerations: All reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented, e.g. failure of arthroplasty. Fusion is a consideration particularly in the young patient who desires a lifestyle that would subject the knee to high mechanical stresses. The patient should understand that the leg will be shortened and there may be difficulty with sitting in confined spaces, and climbing stairs. Although there is generally a painless knee, up to 50 percent of cases may have complications.

i. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform

activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

ii. Because smokers have a higher risk of delayed bone healing and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures. Open reduction internal fixation (ORIF) with possible bone grafting. External fixation or intramedullary rodding may also be used.

g. Post-operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Section F. Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

ii. When boney union is achieved, treatment usually includes active therapy with or without passive therapy, including gait training and ADLs. Non weight-bearing or limited weight-bearing and modified duty may last up to four and six months.

iii. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

3. Ankle Arthroplasty

a. Description/Definition: Prosthetic replacement of the articulating surfaces of the ankle joint.

b. Occupational Relationship: Usually from post-traumatic arthritis.

c. Specific Physical Exam Findings: Stiff, painful ankle. Limited range-of-motion of the ankle joint.

d. Diagnostic Testing Procedures: Radiographs, MRI, diagnostic injections, CT scan, bone scan.

e. Surgical Indications/Considerations: When pain interferes with ADLs, and all reasonable conservative measures have been exhausted and other reasonable surgical options have been considered or implemented. A very limited population of patients are appropriate for ankle arthroplasty.

i. Requirements include:

- (a). Good bone quality;
- (b). BMI less than 35;
- (c). Non-smoker currently;
- (d). Patient is 60 or older;
- (e). No lower extremity neuropathy;
- (f). Patient does not pursue physically demanding work or recreational activities.

ii. The following issues should be addressed when determining appropriateness for surgery: ankle laxity, bone alignment, surrounding soft tissue quality, vascular status, presence of avascular necrosis, history of open fracture or infection, motor dysfunction, and treatment of significant knee or hip pathology.

iii. Ankle implants are less successful than similar procedures in the knee or hip. There are no good studies

comparing arthrodesis and ankle replacement. Patients with ankle fusions generally have good return to function and fewer complications than those with joint replacements. Re-operation rates may be higher in ankle arthroplasty than in ankle arthrodesis. Long-term performance beyond ten years for current devices is still unclear. Salvage procedures for ankle replacement include revision with stemmed implant or allograft fusion. Given these factors, an ankle arthroplasty requires prior authorization and a second opinion by a surgeon specializing in lower extremity surgery.

iv. Contraindications—severe osteoporosis, significant general disability due to other medical conditions, psychiatric issues.

v. In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

vi. Prior to surgery, patients may be assessed for any associated mental health or low back pain issues that may affect rehabilitation.

vii. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

viii. Because smokers have a higher risk of delayed bone healing and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures: Prosthetic replacement of the articular surfaces of the ankle; DVT prophylaxis is not always required but should be considered for patients who have any risk factors for thrombosis.

i. Complications include pulmonary embolism, infection, bony lysis, polyethylene wear, tibial loosening, instability, malalignment, stiffness, nerve-vessel injury, and peri-prosthetic fracture.

g. Post-Operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist while using therapies as outlined in Section F. Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

ii. NSAIDs may be used for pain management after joint replacement. They have also been used to reduce heterotopic ossification after ankle arthroplasty. NSAIDs do reduce the radiographically documented heterotopic ossification in this setting, but there is some evidence (in literature on hip arthroplasty) that they do not improve functional outcomes and they may increase the risk of bleeding events in the post-operative period. Their routine use for prevention of heterotopic bone formation is not recommended.

iii. Treatment may include the following: bracing, active therapy with or without passive therapy, gait training, and ADLs. Rehabilitation post-operatively may need to be specifically focused based on the following problems: contracture, gastrocnemius muscle weakness, and foot and ankle malalignment. Thus, therapies may include braces, shoe lifts, orthoses, and electrical stimulation accompanied by focused therapy.

iv. In some cases aquatic therapy may be used. Refer to Therapeutic Procedures, Non-operative Aquatic Therapy. Pool exercises may be done initially under therapist's or surgeon's direction then progressed to an independent pool program.

v. Prior to revision surgery there should be an evaluation to rule out infection.

vi. Return to work and restrictions after surgery may be made by a treating physician experienced in occupational medicine in consultation with the surgeon or by the surgeon. Patient should be able to return to sedentary work within four to six weeks. Some patients may have permanent restrictions based on their job duties.

vii. Patients are usually seen annually after initial recovery to check plain x-rays for signs of loosening.

#### 4. Knee Arthroplasty

a. Description/Definition: Prosthetic replacement of the articulating surfaces of the knee joint.

b. Occupational Relationship: Usually from post-traumatic osteoarthritis.

c. Specific Physical Exam Findings: Stiff, painful knee, and possible effusion.

d. Diagnostic Testing Procedures: Radiographs.

e. Surgical Indications/Considerations: Severe osteoarthritis and all reasonable conservative measures have been exhausted and other reasonable surgical options have been considered or implemented. Significant changes such as advanced joint line narrowing are expected. Refer to subsection Aggravated Osteoarthritis.

i. Younger patients, less than 50 years of age, may be considered for unicompartmental replacement if there is little or no arthritis in the lateral compartment, there is no inflammatory disease and/or deformity and BMI is less than 35. They may be considered for lateral unicompartmental disease when the patient is not a candidate for osteotomy. Outcome is better for patients with social support.

ii. Contraindications - severe osteoporosis, significant general disability due to other medical conditions, psychiatric issues.

iii. In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

iv. Prior to surgery, patients may be assessed for any associated mental health or low back pain issues that may affect rehabilitation.

v. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative

treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial- and full-disability expected post-operatively.

vi. Because smokers have a higher risk of delayed bone healing and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures: Prosthetic replacement of the articular surfaces of the knee; total or uni-compartmental with DVT prophylaxis. May include patellar resurfacing and computer assistance.

i. There is currently conflicting evidence on the effectiveness of patellar resurfacing. Isolated patellofemoral resurfacing is performed on patients under 60 only after diagnostic arthroscopy does not reveal any arthritic changes in other compartments. The diagnostic arthroscopy is generally performed at the same time as the resurfacing. Resurfacing may accompany a total knee replacement at the discretion of the surgeon.

ii. Computer guided implants are more likely to be correctly aligned. The overall long-term functional result using computer guidance is unclear. Decisions to use computer assisted methods depend on surgeon preference and age of the patient as it is more likely to have an impact on younger patients with longer expected use and wear of the implant. Alignment is only one of many factors that may affect the implant longevity.

iii. Complications occur in around 3 percent and include pulmonary embolism; infection, bony lysis, polyethylene wear, tibial loosening, instability, malalignment, stiffness, patellar tracking abnormality, nerve-vessel injury, and peri-prosthetic fracture.

g. Post-operative Treatment:

i. Anti coagulant therapy to prevent deep vein thrombosis. Refer to Therapeutic Procedures, Non-operative.

ii. NSAIDs may be used for pain management after joint replacement. They have also been used to reduce heterotopic ossification after knee arthroplasty. NSAIDs do reduce the radiographically documented heterotopic ossification in this setting, but there is some evidence (in literature on total hip arthroplasty) that they do not improve functional outcomes and they may increase the risk of bleeding events in the post-operative period. Their routine use for prevention of heterotopic bone formation is not recommended.

iii. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

iv. Treatment may include the following: bracing and active therapy with or without passive therapy. Rehabilitation post-operatively may need to be specifically focused based on the following problems: knee flexion contracture, quadriceps muscle weakness, knee flexion deficit, and foot, and ankle malalignment. Thus, therapies may include, knee braces, shoe lifts, orthoses, and electrical stimulation, accompanied by focused active therapy.

v. In some cases aquatic therapy may be used. Refer to Therapeutic Procedures, Non-operative, Aquatic Therapy. Pool exercises may be done initially under therapist's or surgeon's direction then progressed to an independent pool program.

vi. Continuous passive motion is frequently prescribed. The length of time it is used will depend on the patient and their ability to return to progressive exercise.

vii. Consider need for manipulation under anesthesia if there is less than 90 degrees of knee flexion after six weeks.

viii. Prior to revision surgery there should be an evaluation to rule out infection.

ix. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon. Patient should be able to return to sedentary work within four to six weeks. Some patients may have permanent restrictions based on their job duties.

x. Patients are usually seen annually after initial recovery to check plain x-rays for signs of loosening.

#### 5. Hip Arthroplasty

a. Description/Definition: Prosthetic replacement of the articulating surfaces of the hip joint. In some cases, hip resurfacing may be performed.

b. Occupational Relationship: Usually from post-traumatic arthritis, hip dislocations and femur or acetabular fractures. Patients with intracapsular femoral fractures have a risk of developing avascular necrosis of the femoral head requiring treatment months to years after the initial injury.

c. Specific Physical Exam Findings: Stiff, painful hip.

d. Diagnostic Testing Procedures: Standing pelvic radiographs demonstrating joint space narrowing to 2 mm or less, osteophytes or sclerosis at the joint. MRI may be ordered to rule out other more serious disease.

e. Surgical Indications/Considerations: Severe osteoarthritis and all reasonable conservative measures have been exhausted and other reasonable surgical options have been considered or implemented. Refer to subsection Aggravated Osteoarthritis.

i. Possible contraindications - inadequate bone density, prior hip surgery, and obesity.

ii. In cases where surgery is contraindicated due to obesity, it may be appropriate to recommend a weight loss program if the patient is unsuccessful losing weight on their own. Coverage for weight loss would continue only for motivated patients who have demonstrated continual progress with weight loss.

iii. Prior to surgery, patients may be assessed for any associated mental health or low back pain issues that may affect rehabilitation.

iv. For patients undergoing total hip arthroplasty, there is some evidence that a pre-operative exercise conditioning program, including aquatic and land-based exercise, results in quicker discharge to home than pre-operative education alone without an exercise program.

v. Aseptic loosening of the joint requiring revision surgery occurs in some patients. Prior to revision the joint should be checked to rule out possible infection which may require a bone scan as well as laboratory

procedures, including a radiologically directed joint aspiration.

vi. Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures: Prosthetic replacement of the articular surfaces of the hip, ceramic or metal prosthesis, with DVT prophylaxis. Ceramic prosthesis is more expensive; however, it is expected to have greater longevity and may be appropriate in some younger patients. Hip resurfacing, metal on metal, is an option for younger or active patients likely to out-live traditional total hip replacements.

i. Complications include, leg length inequality, deep venous thrombosis with possible pulmonary embolus, hip dislocation, possible renal effects, need for transfusions, future infection, need for revisions, fracture at implant site.

ii. The long-term benefit for computer assisted hip replacements is unknown. It may be useful in younger patients. Prior authorization is required.

iii. Robotic assisted surgery is considered experimental and not recommended due to technical difficulties.

g. Post-operative Treatment:

i. Anti coagulant therapy is used to prevent deep vein thrombosis. Refer to Therapeutic Procedures, Non-operative.

ii. NSAIDs may be used for pain management after joint replacement. They have also been used to reduce heterotopic ossification after hip arthroplasty. NSAIDs do reduce the radiographically documented heterotopic ossification in this setting, but there is some evidence that they do not improve functional outcomes and they may increase the risk of bleeding events in the post-operative period. Their routine use for prevention of heterotopic bone formation is not recommended.

iii. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using the therapies as outlined in Therapeutic Procedures Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing and exercise progressions.

iv. Treatment usually includes active therapy with or without passive therapy with emphasis on gait training with appropriate assistive devices. Patients with accelerated return to therapy appear to do better. Therapy should include training on the use of adaptive equipment and home and work site evaluation when appropriate.

(a). There is good evidence for the use of aquatic therapy. Refer to Therapeutic Procedures, Non-operative. Pool exercises may be done initially under a therapist's or surgeon's direction then progressed to an independent pool program.

(b). There is some evidence that, for patients older than 60, early multidisciplinary therapy may shorten hospital stay and improve activity level for those receiving hip replacement. Therefore, this may be used for selected patients.

v. Return to activities at four to six weeks with appropriate restrictions by the surgeon. Initially range of

motion is usually restricted. Return to activity after full recovery depends on the surgical approach. Patients can usually lift, but jogging and other high impact activities are avoided.

vi. Helical CT or MRI with artifact minimization may be used to investigate prosthetic complications. The need for implant revision is determined by age, size of osteolytic lesion, type of lesion and functional status. Revision surgery may be performed by an orthopedic surgeon in cases with chronic pain and stiffness or difficulty with activities of daily living. Prior authorization is required and a second opinion by a surgeon with special expertise in hip/knee replacement surgery should usually be performed.

vii. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

viii. Patients are usually seen annually after the initial recovery to check plain x-rays for signs of loosening.

#### 6. Amputation

a. Description/Definition: Surgical removal of a portion of the lower extremity.

b. Occupational Relationship: Usually secondary to post-traumatic bone, soft tissue, vascular or neurologic compromise of part of the extremity.

c. Specific Physical Exam Findings: Non-useful or non-viable portion of the lower extremity.

d. Diagnostic Testing Procedures: Radiographs, vascular studies, MRI, bone scan.

e. Surgical Indications/Considerations: Non-useful or non-viable portion of the extremity.

i. Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

f. Operative Procedures: Amputation.

g. Post-Operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative.

ii. Rigid removable dressings are used initially.

iii. Therapies usually include active therapy with or without passive therapy for prosthetic fitting, construction and training, protected weight-bearing, training on the use of adaptive equipment, and home and jobsite evaluation. Temporary prosthetics are used initially with a final prosthesis fitted by the second year. Multiple fittings and trials may be necessary to assure the best functional result.

iv. For prosthesis with special adaptive devices, e.g. computerized prosthesis; prior authorization and a second opinion from a physician knowledgeable in prosthetic rehabilitation and who has a clear description of the patients expected job duties and daily living activities are required.

v. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

#### 6. Manipulation under anesthesia

a. Description/Definition: Passive range of motion of a joint under anesthesia.

b. Occupational Relationship: Joint stiffness that usually results from a traumatic injury, compensation related surgery, or other treatment.

c. Specific Physical Exam Findings: Joint stiffness in both active and passive modes.

d. Diagnostic Testing Procedures: Radiographs. CT, MRI, diagnostic injections.

e. Surgical Indications/Considerations: Consider if routine therapeutic modalities, including therapy and/or dynamic bracing, do not restore the degree of motion that should be expected after a reasonable period of time, usually at least 12 weeks.

f. Operative Treatment: Not applicable.

g. Post-Operative Treatment:

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. Therapy includes a temporary increase in frequency of both active and passive therapy to maintain the range of motion gains from surgery.

ii. Continuous passive motion is frequently used post-operatively.

iii. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

#### 7. Osteotomy

a. Description/Definition: A reconstructive procedure involving the surgical cutting of bone for realignment. It is useful for patients that would benefit from realignment in lieu of total joint replacement.

b. Occupational Relationship: Post-traumatic arthritis or deformity.

c. Specific Physical Exam Findings: Painful decreased range of motion and/or deformity.

d. Diagnostic Testing Procedures: Radiographs, MRI scan, CT scan.

e. Surgical Indications/Considerations: Failure of non-surgical treatment when avoidance of total joint arthroplasty is desirable. For the knee, joint femoral osteotomy may be desirable for young or middle age patients with varus alignment and medial arthritis or valgus alignment and lateral compartment arthritis. High tibial osteotomy is also used for medial compartment arthritis. Multi-compartmental degeneration is a contraindication. Patients should have a range of motion of at least 90 degrees of knee flexion. For the ankle supra malleolar osteotomy may be appropriate. High body mass is a relative contraindication.

i. Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively. Physicians may monitor smoking cessation with laboratory tests such as cotinine levels for long-term cessation.

f. Operative Procedures: Peri-articular opening or closing wedge of bone, usually with grafting and internal or external fixation.

i. Complications—new fractures, lateral peroneal nerve palsy, infection, delayed unions, compartment syndrome, or pulmonary embolism.

g. Post-Operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative. In all cases, communication between the physician and therapist is important to the timing of weight-bearing, and exercise progressions.

ii. Weight-bearing and range-of-motion exercises depend on the type of procedure performed. Partial or full weight-bearing restrictions can range from six weeks partial weight-bearing, to three months full weight-bearing. It is usually six months before return to sports or other rigorous physical activity.

iii. If femoral intertrochanteric osteotomy has been performed, there is some evidence that electrical bone growth stimulation may improve bone density. Refer to Therapeutic Procedures, Non-operative, Bone Growth Stimulators for description.

iv. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

8. Hardware removal. Hardware removal frequently occurs after initial MMI. Physicians should document the possible need for hardware removal and include this as treatment in their final report.

a. Description/Definition: Surgical removal of internal or external fixation device, commonly related to fracture repairs.

b. Occupational Relationship: Usually following healing of a post-traumatic injury that required fixation or reconstruction using instrumentation.

c. Specific Physical Exam Findings: Local pain to palpation, swelling, erythema.

d. Diagnostic Testing Procedures: Radiographs, tomography, CT scan, MRI.

e. Surgical Indications/Considerations: Persistent local pain, irritation around hardware.

f. Operative Procedures: Removal of hardware may be accompanied by scar release/resection, and/or manipulation. Some instrumentation may be removed in the course of standard treatment without symptoms of local irritation.

g. Post-Operative Treatment

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative.

ii. Treatment may include therapy with or without passive therapy for progressive weight-bearing, range of motion.

iii. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

9. Release of Contracture

a. Description/Definition: Surgical incision or lengthening of contracted tendon or peri-articular soft tissue.

b. Occupational Relationship: Usually following a post-traumatic complication.

c. Specific Physical Exam Findings: Shortened tendon or stiff joint.

d. Diagnostic Testing Procedures: Radiographs, CT scan, MRI scan.

e. Surgical Indications/Considerations: Persistent shortening or stiffness associated with pain and/or altered function.

i. Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and be provided with appropriate counseling by the physician.

f. Operative Procedures: Surgical incision or lengthening of involved soft tissue.

g. Post-operative Treatment:

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist and using therapies as outlined in Therapeutic Procedures, Non-operative.

ii. Treatments may include active therapy with or without passive therapy for stretching, range of motion exercises.

iii. Return to work and restrictions after surgery may be made by an attending physician experienced in occupational medicine in consultation with the surgeon or by the surgeon.

10. Human Bone Morphogenetic Protein (RhBMP)

a. (RhBMP) is a member of a family of proteins which are involved in the growth, remodeling, and regeneration of bone tissue. It has become available as a recombinant biomaterial with osteo-inductive potential for application in long bone fracture non-union and other situations in which the promotion of bone formation is desired. RhBMP may be used with intramedullary rod treatment for open tibial fractures an open tibial Type III A and B fracture treated with an intramedullary rod. There is some evidence that it decreases the need for further procedures when used within 14 days of the injury. It should not be used in those with allergies to the preparation, or in females with the possibility of child bearing, or those without adequate neurovascular status or those less than 18 years old. Ectopic ossification into adjacent muscle has been reported to restrict motion in periarticular fractures. Other than for tibial open fractures as described above, it should be used principally for non-union of fractures that have not healed with conventional surgical management or peri-prosthetic fractures. Due to the lack of information on the incidence of complications and overall success rate in these situations, its use requires prior authorization. Refer to Tibial Fracture.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2314. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:  
OWCA—Medical Services  
ATTN: Medical Director  
P.O. Box 94040  
Baton Rouge, LA 70804

1. Social Security No. \_ \_ - \_ - \_
2. Date of Injury/Illness \_ - \_ - \_
3. Parts of Body Injury \_\_\_\_\_
4. Date of Birth \_ - \_ - \_
5. Date of This Request \_ - \_ - \_
6. Claim Number \_\_\_\_\_

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by \_\_\_\_\_ Employee \_\_\_\_\_ Employer \_\_\_\_\_ Insurer \_\_\_\_\_ Health Care Provider \_\_\_\_\_ Other \_\_\_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.

**EMPLOYEE**

8. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYEE'S ATTORNEY**

9. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER**

10. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**INSURER/ADMINISTRATOR  
(circle one)**

11. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER/INSURER'S  
ATTORNEY**

12. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**TREATING/REQUESTING  
PHYSICIAN**

13. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

LWC-WC 1009  
11/2010

14. PLEASE PROVIDE A SUMMARY OF THE DETAILS REGARDING THE ISSUE AT DISPUTE:

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You may attach a letter or petition with additional information with this disputed claim.  
The information given above is true and correct to the best of my knowledge and belief.

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SIGNATURE OF REQUESTING PARTY \_\_\_\_\_ DATE

LWC-WC 1009  
11/2010

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**Chapter 23. Shoulder Injury Medical Treatment Guidelines**

**§2315. Introduction**

A. This document has been prepared by the Louisiana Workforce Commission, Office of Workers' Compensation and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Louisiana's Workers' Compensation Act as injured workers with shoulder injuries. These guidelines are enforceable under the Louisiana Workers Compensation Act. All medical care, services, and treatment owed by the employer to the employee in accordance with the Louisiana Workers' Compensation Act shall mean care, services, and treatment in accordance with these guidelines. Medical Care, services, and treatment that varies from these guidelines shall also be due by the employer when it is demonstrated to the medical director of the office by a preponderance of the scientific medical evidence, that a variance from these guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care. To properly utilize this document, the reader should not skip nor overlook any sections.

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**§2317. General Guideline Principles**

A. The principles summarized in this section are key to the intended implementation of all Office of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. Application of Guidelines. The OWCA provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer, and patient through the Office of Workers Compensation.

2. Education. Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of shoulder injuries. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. Treatment Parameter Duration. Time frames for specific interventions commence once treatments have been

initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document. Such deviation shall be in accordance with La. R.S. 23:1203.1

4. Active Interventions. Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. Active Therapeutic Exercise Program. Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. Positive Patient Response. Positive results are defined primarily as functional gains that can be objectively measured. Standard measurement tools, including outcome measures, should be used.

a. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion (ROM), strength, and endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. Re-evaluation treatment every three to four weeks. If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. Surgical Interventions. Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. Six-Month Time Frame. The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. Return-to-Work. Return to Work is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or

standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. Delayed Recovery. Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The OWCA recognizes that 3 to 10 percent of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. Guideline Recommendations and Inclusion of Medical Evidence. Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

a. "Consensus" means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as "generally well accepted," "generally accepted," "acceptable/accepted," or "well-established."

b. "Some" means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

c. "Good" means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

d. "Strong" means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

B. All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence or consensus statement attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

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#### **§2319. Initial diagnostic procedures**

A. The OWCA recommends the following diagnostic procedures be considered, at least initially, the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established.

Standard procedures that should be utilized when initially diagnosing a work-related shoulder complaint are listed below.

1. History Taking and Physical Examination (Hx & PE) are generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictates subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not complementing each other, the objective clinical findings should have preference. The medical records should reasonably document the following:

- a. History of Present Injury
  - i. Mechanism of injury. This includes details of symptom onset and progression, and documentation of right or left dominance;
  - ii. Relationship to work. This includes a statement of the probability that the illness or injury is work-related;
  - iii. Prior occupational and non-occupational injuries to the same area including specific prior treatment;
  - iv. History of locking, clicking, weakness, acute or chronic swelling, crepitation, pain while lifting or performing overhead work, dislocation or popping. Pain or catching with overhead motion may indicate a labral tear. Night time pain can be associated with specific shoulder pathology. Anterior joint pain, such as that seen in throwing athletes, may indicate glenohumeral instability. Pain radiating below the elbow, may indicate cervical disc problems or proximal entrapment neuropathy.
  - v. Ability to perform job duties and activities of daily living; and
  - vi. Exacerbating and alleviating factors of the reported symptoms. The physician should explore and report on non-work related as well as, work related activities.
- b. Past History
  - i. Past medical history includes previous shoulder conditions, neoplasm, gout, arthritis, diabetes and previous shoulder symptoms;
  - ii. Review of systems includes symptoms of rheumatologic, neurologic, endocrine, neoplastic, and other systemic diseases;
  - iii. Smoking history; and
  - iv. Vocational and recreational pursuits.
- c. Physical Examination: Examination should include the elbow and neck. Both shoulders should be examined to compare asymptomatic and symptomatic sides and identify individuals with non-pathological joint laxity or degenerative rotator cuff pathology. Physical examinations should consist of accepted tests and exam techniques applicable to the joint or area being examined, including:
  - i. visual inspection;
  - ii. palpation, including the acromio-clavicular (AC) joint, sternoclavicular joint, and the subacromial bursa in the region of the acromioclavicular sulcus;
  - iii. range-of-motion/quality of motion;
  - iv. strength, shoulder girdle weakness may indicate musculoskeletal or neurogenic pathology;
  - v. joint stability;
  - vi. integrity of distal circulation and limited neurologic exam;
  - vii. cervical spine evaluation; and

viii. if applicable, full neurological exam including muscle atrophy and gait abnormality.

ix. specific shoulder tests

(a). This section contains a description of common clinical shoulder tests. Generally, more than one test is needed to make a diagnosis. Clinical judgment should be applied when considering which tests to perform, as it is not necessary to perform all of the listed tests on every patient. The physical examination may be non-specific secondary to multi-faceted pathology in many patients, and because some tests may be positive for more than one condition. Given the multitude of tests available, the physician is encouraged to document the specific patient response, rather than report that a test is 'positive.' The tests are listed for informational purposes, and are also referenced in Specific Diagnostic, Testing and Treatment Procedures.

(i). Rotator cuff/Impingement tests/Signs - Most published clinical examination studies assess rotator cuff pathology. There is some evidence that tests are reliable for ruling out diagnoses, but not necessarily defining the pathology accurately. Some studies indicate that the Neer test, Hawkins test, Jobe test, crossed-arm adduction test, impingement sign and arc of pain are approximately 80 percent sensitive for impingement or rotator cuff pathology. The drop arm, Yergason's, Speed, and passive external Rotation Tests are thought to have specificity of 60 percent or higher. (Questions remain about interrater reliability.)

[a]. Weakness with abduction.

[b]. Arc of pain – Pain with 60 to 120 degrees of abduction.

[c]. Neer impingement sign – Examiner flexes arm anteriorly to reproduce impingement. Positive if pain is reproduced.

[d]. Neer impingement test – When the Neer impingement sign is positive, the subacromial bursa is injected with local anesthetic. If, after 40 minutes, the patient has sufficient pain relief so that the examiner can perform the Neer impingement sign without recreating the initial pain, the test suggests impingement.

[e]. Hawkins - arm is abducted to 90 degrees, forward flexed by 90 degrees with elbow flexed. Examiner internally rotates the humerus. Pain suggests impingement.

[f]. Drop arm - Patient slowly lowers arm from full abduction. If the arm drops, or if the patient is unable to maintain slow progress from approximately 90 degrees, the test suggests rotator cuff tear.

[g]. Lift off - patient's hand is placed against back of waist with 90 degrees flexion of elbow. The patient is asked to lift the hand off of his back at waist level. If the hand drops to the initial position against the back, this suggests subscapularis tear or weakness. Some patients may not be able to perform the initial hand placement due to pain or limited range-of-motion.

[h]. Subscapularis strength test - Patient places hand on mid-abdomen, and then applies pressure. If the elbow moves posteriorly or the wrist flexes, the test suggests subscapularis weakness or tear.

[i]. Empty Can test - Patient's arm abducted to 60 to 90 degrees with 30 degrees forward flexion and with forearm pronated. Thumbs are pointing toward the floor. Patient resists examiner's downward

pressure on the elbow. Weakness of the affected side, compared to the opposite side, or pain in subacromial area suggests supraspinatus tear, tendonitis or tendonosis.

[j]. External rotation lag test - the patient's arm is abducted to 20 degrees with elbow flexed at 90 degrees, and almost fully externally rotated. If the patient cannot maintain the arm in external rotation, this suggests a supraspinatus and/or infraspinatus tear.

[k]. External rotation weakness - Elbows are flexed with arms at side, and patient attempts to externally rotate against resistance. Weakness suggests infraspinatus and teres minor pathology.

[l]. Impingement sign - Patient extends shoulder, then abducts and reports any pain

(ii). Acromioclavicular Joint Tests

[a]. Crossed arm adduction - Examiner adducts arm across the body as far as possible toward the opposite shoulder. If patient reports pain in the AC joint, this suggests AC joint pathology. Examiner may measure the distance between antecubital fossa and the opposite acromion of the opposite shoulder. If one shoulder demonstrates increased distance compared to the other shoulder, this suggests a tight posterior capsule.

[b]. Paxino's - The examiner's thumb is placed under the posterolateral aspect of the acromion, with the index and long fingers on the superior aspect of middle part of the clavicle. Examiner applies anterior superior pressure to acromion with thumb, and pushes inferiorly on the middle of the clavicle with index and long fingers. If the patient reports increased pain in the AC joint, the test suggests AC joint pathology.

(iii). Labral Tears

[a]. Labral tears which may require treatment usually occur with concurrent bicipital tendon disorders pathology and/or glenohumeral instability. Therefore, tests for labral pathology are included in these sections.

(iv). Bicipital Tendon Disorders

[a]. Yergason's Test - The patient has the elbow flexed to 90 degrees. The examiner faces the patient, grasps the patient's hand with one hand and palpates the bicipital groove with the other. The patient supinates the forearm against resistance. If the patient complains of pain in the biceps tendon with resistance, it suggests a positive finding.

[b]. Ludington's - The patient's hands are placed behind the head, with the shoulders in abduction and external rotation. If biceps contraction recreates pain, the test suggests biceps tendon pathology.

[c]. Speed Test - The patient's shoulder is flexed to 90 degrees and supinated. The examiner provides resistance to forward flexion. If pain is produced with resistance, the test suggests biceps tendon instability or tendonitis.

[d]. Biceps Load Test II - The patient is supine with the arm elevated to 120 degrees, externally rotated to maximum point, with elbow in 90 degrees of flexion and the forearm supinated. The examiner sits adjacent to the patient on the same side, and grasps the patient's wrist and elbow. The patient flexes the elbow, while the examiner resists. If the patient complains of pain with resistance to elbow flexion, or if the pain is increased with

resisted elbow flexion, this may suggest a biceps related SLAP lesion in young patients.

(v). Glenohumeral Instability/Labral Tears/SLAP Lesions. Many of the following tests are also used to test for associated labral tears. The majority of the tests/signs should be performed on both shoulders for comparison. Some individuals have increased laxity in all joints, and therefore, tests/signs which might indicate instability in one individual may not be pathologic in individuals whose asymptomatic joint is equally lax.

[a]. Sulcus sign - With the patient's arm at the side, the examiner pulls inferiorly and checks for deepening of the sulcus, a large dimple on the lateral side of the shoulder. Deepening of the sulcus suggests instability.

[b]. Inferior instability - With patient's arm abducted to 90 degrees, examiner pushes down directly on mid-humerus. Patient may try to drop the arm to the side to avoid dislocation.

[c]. Posterior instability - The patient's arm is flexed to 90 degrees anteriorly and examiner applies posterior force to the humerus. The examiner then checks for instability.

[d]. Apprehension - Patient's shoulder is in 90 degrees of abduction and in external rotation. Examiner continues to externally rotate and apply axial force to the humerus. If there is pain, or if patient asks to stop, the test suggests anterior instability.

[e]. Relocation - Examiner applies posterior force on humerus while externally rotating. This is performed in conjunction with the apprehension test. If symptoms are reduced, the test suggests anterior instability.

[f]. Load and shift or anterior and posterior drawer - Patient is supine or seated with arm abducted from shoulder from 20 to 90 degrees and elbow flexed. Humerus is loaded by examiner, then examiner attempts to shift the humeral head anterior, posterior, or inferior. Both shoulders should be tested. Results are graded using:

[i]. Grade 0, little or no movement;

[ii]. Grade 1, humeral head glides beyond the glenoid labrum; and

[iii]. Grades 2 & 3 actual dislocation of the humeral head off the glenoid.

[g]. Anterior slide or Kibler test - Patient places hands on hips with thumb directed posteriorly. Examiner applies force superiorly and anteriorly on the humerus, while the patient resists. If a click or deep pain results, test suggests labral tear.

[h]. Active compression (O'Brien) test - The patient has the shoulder in 90 degrees flexion and 10 to 15 degrees adduction. The arm is internally rotated so the thumb is pointing downward. The patient elevates the arm while the examiner resists. If the patient experiences deep anterior shoulder pain that is relieved when the same process is repeated with external rotation of the arm, the test suggests labral tear or AC joint pathology.

[i]. Crank test - The patient is standing and has arm elevated to 160 degrees in the scapular plane. The examiner loads the glenohumeral joint while the arm is passively rotated internally and externally. The test is repeated in the supine position. Pain, clicking, popping, or

other mechanical grinding suggests labral tear and possible instability.

[j]. Compression rotation test – The patient is supine with shoulder abducted at 90 degrees. The examiner applies an axial load across the glenohumeral joint while simultaneously passively rotating the patient’s arm in internal and external rotation. Pain, clicking, popping, or other mechanical grinding suggests a labral tear and possible instability.

[k]. Pain provocation or Mimori test – The patient is seated upright with the shoulder in 90 degrees abduction. The examiner maximally pronates and supinates the forearm while maintaining the shoulder at 90 degrees abduction. A positive test is suggested when pain or pain severity, is greater with the forearm pronated.

(vi). Functional assessment. The provider should assess the patient’s functional skills initially and periodically during treatment. The initial exam will form the baseline for the patient’s functional abilities post- injury. This assessment will help the physician and patient determine when progress is being made and whether specific therapies are having a beneficial effect. A number of functional scales are available that have been validated in clinical research settings. Many of these scales were developed to evaluate specific diagnoses and will not be useful for all patients with shoulder pain. The following areas are examples of functional activities the provider may assess:

- [a]. interference with sleep;
- [b]. difficulty getting dressed or combing or washing hair;
- [c]. ability to do the household shopping alone;
- [d]. ability to shower or bath and dry oneself using both hands;
- [e]. ability to carry a tray of food across a room with both hands;
- [f]. ability to hang up clothes in the closet;
- [g]. ability to reach high shelves with the affected shoulder;
- [h]. difficulty with any other activities including sports and work duties;
- [i]. concerns about putting on overhead clothing;
- [j]. concerns that a specific activity might cause the shoulder to “go out”;
- [k]. a detailed description of ability to perform job duties.

[l]. any positive historical information should be validated by the provider’s physical exam.

2. Radiographic Imaging of the shoulder is a generally accepted, well-established and widely used diagnostic procedure when specific indications based on history and/or physical examination are present. It should not be routinely performed for most non-traumatic diagnoses. The mechanism of injury and specific indications for the radiograph should be listed on the request form to aid the radiologist and x-ray technician. For additional specific clinical indications, Specific Diagnosis, Testing and Treatment Procedures. Indications include:

- a. inability to actively move arm through range-of-motion;

- b. history of significant trauma, especially blunt trauma or fall from a height;
- c. history of dislocation;
- d. age over 55 years;
- e. unexplained or persistent shoulder pain over two weeks. (Occult fractures, may not be visible on initial x-ray. A follow-up radiograph and/or bone scan may be required to make the diagnosis);
- f. history or exam suggestive of intravenous drug abuse or osteomyelitis; and
- g. pain with swelling and/or range-of-motion (ROM) limitation localizing to an area of prior fracture, internal fixation, or joint prosthesis.

3. Laboratory tests are generally accepted, well-established and widely used procedures. They are, however, rarely indicated at the time of initial evaluation, unless there is suspicion of systemic illness, infection, neoplasia, connective tissue disorder, or underlying arthritis or rheumatologic disorder based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. The OWCA recommends that lab diagnostic procedures be initially considered the responsibility of the workers' compensation carrier to ensure that an accurate diagnosis and treatment plan can be established. Tests include, but are not limited to:

- a. Completed Blood Count (CBC) with differential can detect infection, blood dyscrasias, and medication side effects;
- b. Erythrocyte sedimentation rate, rheumatoid factor, antinuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein can be used to detect evidence of a rheumatologic, infection, or connective tissue disorder;
- c. Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase can detect metabolic bone disease;
- d. Liver and kidney function may be performed for prolonged anti-inflammatory use or other medications requiring monitoring; and
- e. Analysis of joint aspiration for bacteria, white cell count, red cell count, fat globules, crystalline birefringence and chemistry to evaluate joint effusion.

#### 7. Other Procedures

a. Joint Aspiration: is a generally accepted, well-established and widely used procedure when specifically indicated and performed by individuals properly trained in these techniques. Especially, when history and/or physical examination are of concern for a septic joint or bursitis. Aspiration of a large effusion can help to decrease pain and speed functional recovery. Persistent or unexplained effusions may be examined for evidence of infection, rheumatologic, or inflammatory processes. The presence of fat globules in the effusion strongly suggests occult fracture.

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#### **§2321. Follow-Up diagnostic imaging and testing procedures**

A. One diagnostic imaging procedure may provide the same or distinctive information as does another procedure. Therefore, the prudent choice of a single diagnostic

procedure, a complement of procedures or a sequence of procedures will optimize diagnostic accuracy; maximize cost effectiveness (by avoiding redundancy), and minimize potential adverse effects to patients.

B. All diagnostic imaging procedures have a significant percentage of specificity and sensitivity for various diagnoses. None is specifically characteristic of a certain diagnosis. Clinical information obtained by history taking and physical examination should form the basis for selecting an imaging procedure and interpreting its results.

C. When a diagnostic procedure, in conjunction with clinical information, can provide sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient's tolerance, and/or the treating practitioner's familiarity with the procedure.

1. Imaging Studies are generally accepted, well-established and widely used diagnostic procedures. When indicated, the following additional imaging studies can be utilized for further evaluation of the shoulder, based upon the mechanism of injury, symptoms, and patient history. For specific clinical indications, refer to Specific Diagnosis, Testing and Treatment Procedures. The studies below are listed by frequency of use, not importance. Diagnostic imaging may be useful in resolving the diagnostic uncertainties that remain after the clinical examination. Even a thorough history and physical examination may not define the shoulder pathology that produces the patient's symptoms. Therefore, additional investigations should be considered as an accepted part of the patient evaluation when surgery is being considered or clarification of diagnosis is necessary to formulate a treatment plan.

a. X-ray is widely accepted and frequently the first imaging study performed. Three radiographically distinguishable acromion types have been described: Type I (flat), Type II (curved), and Type III (hooked). Historically, acromion type was correlated with incidence of rotator cuff pathologies and with outcome of nonsurgical treatment of shoulder pain. However, there is considerable variation between observers regarding the acromial types, both in interpreting plain x-rays and in classifying anatomical specimens. Acromial morphology should not be used to assess the likelihood of rotator cuff pathology. Acromial morphology alone should not be considered an indication for acromioplasty, as up to 40 percent of asymptomatic adults may have a Type II acromion. Appropriate soft tissue imaging techniques such as sonography and MRI should be used to assess rotator cuff or bursa status.

b. Diagnostic Sonography is an accepted technique for suspected full-thickness tears. A positive sonogram has a high specificity of 96 percent and provides convincing confirmation of the diagnosis. Sensitivity is high, 87 percent, however, negative sonography does not rule out a full-thickness tear. For partial thickness tears, a positive sonogram has high specificity, 94 percent, but is only moderately sensitive, 67 percent. A negative sonogram does not exclude the diagnosis of a partial thickness tear. The

performance of sonography is operator-dependent, and is best when done by a specialist in musculoskeletal radiology. It is preferable to MRI when the patient is claustrophobic or has inserted medical devices.

c. Magnetic Resonance Imaging (MRI) is generally accepted and widely used to provide a more definitive visualization of soft tissue structures, including ligaments, tendons, joint capsule, and joint cartilage structures, than x-ray or Computed Axial Tomography (CT) in the evaluation of traumatic or degenerative injuries. The addition of intravenous or intra-articular contrast can enhance definition of selected pathologies. In general, the high field, conventional, MRI provides better resolution than a low field scan. A lower field scan may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation. Inadequate resolution on the first scan may require a second MRI using a different technique. All questions in this regard should be discussed with the MRI center and/or radiologist. MRI provides excellent soft tissue detail, but interpretation of the image is problematic and depends on operator skill. A positive MRI has high specificity of 93 percent and provides supporting evidence that a clinical suspicion of a full-thickness tear is correct. Sensitivity of MRI for full-thickness tears is also high at 89 percent. However, it may not identify the pathology in some cases. For partial thickness tears, sensitivity of MRI is below 50 percent but its specificity is high at 90 percent.

d. Computed Axial Tomography (CT): is generally accepted and provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic window evaluation. Instrument scatter-reduction software provides better resolution when metallic artifact is of concern.

e. MR Arthrography (MRA): This accepted investigation uses the paramagnetic properties of gadolinium to shorten T1 relaxation times and provide a more intense MRI signal. It can accurately demonstrate and rule out full-thickness tears as well as non-contrast MRI, but it is invasive and its place in the evaluation of rotator cuff pathology has not been determined. In select populations of highly active athletes, it may uncover unsuspected labral pathology such as SLAP lesions, but the arthroscopically normal labrum may produce an abnormal signal in half of MRA studies. Its contribution to the diagnosis of SLAP lesions has not been determined. An MRA is not necessary if the patient has already met indications for arthroscopy or surgery as outlined in Specific Diagnosis, Testing and Treatment. However, an MRA may be ordered when the surgeon desires further information prior to surgery.

f. Venogram/Arteriogram is a generally accepted test is useful for investigation of vascular injuries or disease, including deep-venous thrombosis. Potential complications may include pain, allergic reaction, and deep-vein thrombosis.

g. Bone Scan (Radioisotope Bone Scanning): is generally accepted, well-established and widely used. Bone scanning is more sensitive but less specific than MRI. <sup>99m</sup>Tc diphosphonate uptake reflects osteoblastic activity and may be useful in metastatic/primary bone tumors, stress fractures, osteomyelitis, and inflammatory lesions, but cannot distinguish between these entities. Bone

scanning is more sensitive but less specific than MRI. It is useful for the investigation of trauma, infection, stress fracture, occult fracture, Complex Regional Pain Syndrome, and suspected neoplastic conditions of the upper extremity.

h. Other Radioisotope Scanning Indium and gallium scans are generally accepted procedures usually to help diagnose lesions seen on other diagnostic imaging studies. 67Gallium citrate scans are used to localize tumor, infection, and abscesses. 111Indium-labeled leukocyte scanning is utilized for localization of infection or inflammation.

i. Arthrograms are accepted; however, rarely used except for evaluation of patients with metal implants and previous shoulder surgery.

j. If the patient has a positive ultrasound, MRI, or Arthrogram – only one of these tests are necessary to diagnose a rotator cuff tear. Any additional tests must be for additional diagnosis.

3. Other Tests. The following diagnostic procedures in this subsection are listed in alphabetical order.

a. Compartment Pressure Testing and Measurement Devices: such as pressure manometer, are generally accepted and useful in the evaluation of patients who present uncommon but reported symptoms consistent with a compartment syndrome.

b. Doppler Ultrasonography/Plethysmography: is useful in establishing the diagnosis of arterial and venous disease in the upper extremity and should be considered prior to the more invasive venogram or arteriogram study.

c. Electrodiagnostic Testing: Electrodiagnostic tests include but are not limited to, Electromyography (EMG), and Nerve Conduction Studies (NCS). These are generally accepted, well-established and widely used diagnostic procedures. Electrodiagnostic studies may be useful in the evaluation of patients with suspected involvement of the neuromuscular system, including radiculopathies, peripheral nerve entrapments, peripheral neuropathies, disorders of the neuromuscular junction and primary muscle disease. EMGs should not be routinely performed for shoulder injuries unless there are findings to suggest new diagnostic pathology (Refer to Brachial Plexus). In general, these diagnostic procedures are complementary to imaging procedures such as CT, MRI, and/or myelography or diagnostic injection procedures. Electrodiagnostic studies may provide useful, correlative neuropathophysiological information that would not be obtainable from standard radiologic studies. Portable Automated Electrodiagnostic Device (also known as Surface EMG) is not a substitute for conventional EMG/NCS testing in clinical decision-making, and therefore, is not recommended.

d. Personality/Psychological/Psychiatric/Psychosocial Evaluation: These are generally accepted and well-established diagnostic procedures with selective use in the upper extremity population, but have more widespread use in subacute and chronic upper extremity populations. Diagnostic testing procedures may be useful for patients with symptoms of depression, delayed recovery, chronic pain, recurrent painful conditions, disability problems, and for preoperative evaluation. Psychological/psychosocial and measures have been shown to have predictive value for postoperative response, and therefore should be strongly considered for use pre-operatively when the surgeon has concerns about the relationship between symptoms and

findings, or when the surgeon is aware of indications of psychological complication or risk factors for psychological complication (e.g. childhood psychological trauma). Psychological testing should provide differentiation between pre-existing conditions versus injury caused psychological conditions, including depression and posttraumatic stress disorder. Psychological testing should incorporate measures that have been shown, empirically, to identify comorbidities or risk factors that are linked to poor outcome or delayed recovery. Formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and test results. In addition to the customary initial exam, the evaluation of the injured worker should specifically address the following areas:

- i. employment history;
- ii. interpersonal relationships-both social and work;
- iii. patient activities;
- iv. current perception of the medical system;
- v. current perception/attitudes toward employer/job
- vi. results of current treatment
- vii. risk factors and psychological comorbidities that may influence outcome and that may require treatment
- viii. childhood history, including history of childhood psychological trauma, abuse and family history of disability.

(a). Personality/psychological/psychosocial evaluations consist of two components, clinical interview and psychological testing. Results should help clinicians with a better understanding of the patient in a number of ways. Thus the evaluation result will determine the need for further psychosocial interventions; and in those cases, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis should be determined and documented. The evaluation should also include examination of both psychological comorbidities and psychological risk factors that are empirically associated with poor outcome and/or delayed recovery. An individual with a Ph.D., Psy.D, or psychiatric M.D./D.O. credentials should perform initial evaluations, which are generally completed within one to two hours. A professional fluent in the primary language of the patient is preferred. When such a provider is not available, services of a professional language interpreter should be provided.

(i). Frequency: one-time visit for the clinical interview. If psychometric testing is indicated as a part of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

4. Special Tests are generally well-accepted tests and are performed as part of a skilled assessment of the patient's capacity to return-to-work, his/her strength capacities, and physical work demand classifications and tolerances. The procedures in this subsection are listed in alphabetical order.

a. Computer Enhanced Evaluations: may include isotonic, isometric, isokinetic and/or isoinertial measurement of movement, range-of-motion (ROM), endurance or strength. Values obtained can include degrees of motion, torque forces, pressures, or resistance. Indications include determining validity of effort, effectiveness of treatment and

demonstrated motivation. These evaluations should not be used alone to determine return to work restrictions. The added value of computer enhanced evaluations is unclear. Targeted work tolerance screening or gradual return to work is preferred.

i. Frequency: One time for evaluation. Can monitor improvements in strength every three to four weeks up to a total of six evaluations.

b. Functional Capacity Evaluation (FCE): is a comprehensive or modified evaluation of the various aspects of function as they relate to the worker's ability to return-to-work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range of motion, coordination and strength, worker habits, employability, as well as psychosocial aspects of competitive employment may be evaluated. Components of this evaluation may include: musculoskeletal screen; cardiovascular profile/aerobic capacity; coordination; lift/carrying analysis; job-specific activity tolerance; maximum voluntary effort; pain assessment/psychological screening; and non-material and material handling activities. When an FCE is being used to determine return to a specific jobsite, the provider is responsible for fully understanding the job duties. A jobsite evaluation is frequently necessary. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering. Full FCEs are sometimes not necessary. If Partial FCEs are performed, it is recognized that all parts of the FCE that are not performed are considered normal. In many cases, a work tolerance screening will identify the ability to perform the necessary job tasks.

i. Frequency: Can be used initially to determine baseline status and for case closure when patient is unable to return to pre-injury position and further information is desired to determine permanent work restrictions. Prior authorization is required for FCEs performed during treatment.

c. Jobsite Evaluation: is a comprehensive analysis of the physical, mental, and sensory components of a specific job. These components may include, but are not limited to; postural tolerance (static and dynamic); aerobic requirements; range of motion; torque/force; lifting/carrying; cognitive demands; social interactions; visual perceptual; sensation; coordination; environmental requirements of a job; repetitiveness; and essential job functions. Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation. A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work. Requests for a jobsite evaluation should describe the expected goals for the evaluation. Goals may include, but are not limited to the following:

i. To determine if there are potential contributing factors to the person's condition and/or for the physician to assess causality;

ii. To make recommendations for, and to assess the potential for ergonomic changes;

iii. To provide a detailed description of the physical and cognitive job requirements;

iv. To assist the patient in their return to work by educating them on how they may be able to do their job more safely in a bio-mechanically appropriate manner; and/or

v. To give detailed work/activity restrictions.

(a). Frequency: One time with additional visits as needed for follow-up visits per jobsite.

d. Vocational Assessment: The vocational assessment should provide valuable guidance in the determination of future rehabilitation program goals. It should clarify rehabilitation goals, which optimize both patient motivation and utilization of rehabilitation resources. If prognosis for return to former occupation is determined to be poor, except in the most extenuating circumstances, vocational assessment should be implemented within 3 to 12 months post-injury. Declaration of MMI should not be delayed solely due to lack of attainment of a vocational assessment.

i. Frequency: One time with additional visits as needed for follow-up

e. Work Tolerance Screening: is a determination of an individual's tolerance for performing a specific job based on a job activity or task and may be used when a full Functional Capacity Evaluation is not indicated. The screening is monitored by a therapist and may include a test or procedure to specifically identify and quantify work-relevant cardiovascular, physical fitness and postural tolerance. It may also address ergonomic issues affecting the patient's return-to-work potential.

i. Frequency: One time for initial screen. May monitor improvements in strength every three to four weeks up to a total of six visits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

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### **§2323. Specific Diagnosis, Testing and Treatment**

A. Acromioclavicular joint sprains/dislocations. An acute acromioclavicular (AC) joint injury is frequently referred to as a shoulder separation. There are six classifications of AC joint separation, which are based upon the extent of ligament damage and bony displacement:

1. Description/Definition:

a. Type I - Sprain of the AC ligament and capsule; x-ray usually normal.

b. Type II - Sprains consisting of a ruptured AC ligament and capsule with incomplete injury to the coracoclavicular (CC) ligament, resulting in mild AC joint subluxation. X-ray shows clavicle slightly elevated.

c. Type III - Dislocation of the clavicle above the acromion with complete tear of the AC ligament and/or CC ligaments; abnormal stress x-rays.

d. Type IV. - Dislocation consisting of a displaced clavicle that penetrates posteriorly through or into the trapezius muscle. The sterno-clavicular joint may also be dislocated.

e. Type V - Dislocation consisting of complete separation of the AC and CC ligaments and dislocation of the acromioclavicular joint with a large coracoclavicular interval.

f. Type VI - Dislocation consisting of a displaced clavicle that penetrates inferior to the coracoid.

2. Type I-III are common, while Types IV-VI are not, and when found require surgical consultation. For AC joint degeneration from repetitive motion that is found to be work-related, refer to Impingement Syndrome.

3. Occupational Relationship: Generally, workers sustain an AC joint injury when they fall landing on the point of the shoulder, driving the acromion downward; or fall on an outstretched hand or elbow with an adducted arm, creating a backward and outward force on the shoulder. It is important to rule out other sources of shoulder pain from the acute injury, including rotator cuff tear, fracture, and nerve injury.

4. Specific Physical Exam Findings may include the following:

a. At times, tenderness at the AC joint with contusions and/or abrasions at the joint area; and/or prominence/asymmetry of the shoulder can be seen;

b. The patient usually demonstrates decreased shoulder motion, and with palpation, the distal end of the clavicle is painful. There may be increased clavicular translation and cross-body adduction that causes exquisite pain at the AC joint. Cross-body adduction with the arm elevated to 90 degrees can also cause posterior pain with a tight posterior capsule, or lateral pain with impingement. Injection of local anesthetic in the AC joint should relieve pain when performing this maneuver.

5. Diagnostic Testing Procedures: Plain x-rays may include:

a. AP view;

b. AP radiograph of the shoulder with the beam angled 10 degrees cephalad (Zanca view) and a beam strength that is under-penetrating;

c. Axillary lateral views; and

d. Stress view; side-to-side comparison with 10 to 15 lb. of weight in each hand.

6. Non-operative Treatment Procedures may include:

a. Procedures outlined in Section F. Immobilization in some cases (up to 6 weeks for Type I-III AC joint separations). Treatments for Type III injuries are controversial and may range from a sling to surgery.

b. Medication, such as non-steroidal anti-inflammatories and analgesics would be indicated. Narcotics are not normally indicated. Lidocaine patches may be used for pain relief. In chronic acromioclavicular joint pain, a series of injections with or without cortisone may be performed up to three times per year. Benefits may be achieved through therapeutic rehabilitation. It should emphasize a progressive increase in range-of-motion (ROM) without exacerbation of the AC joint injury. Full recovery of AC joint dislocation may require up to twelve weeks. With increasing motion and pain control, a strengthening program should be instituted. Refer to Therapeutic Procedures, Non-operative.

c. Return to appropriate modified duty should begin within the first week. Refer to Return to Work. With restoration of full-motion, return to full-duty should be anticipated within three months.

d. Other therapies in Therapeutic Procedures, Non-operative, may be employed in individual cases.

7. Surgical Indications: Patients who have Type III AC joint dislocations will usually recover well without surgical intervention. Surgical intervention may be considered when functional deficits interfere with activities of daily living and/or job duties after three to four months of active patient participation in non-operative therapy. For patients with particularly high physical demands on their shoulder, immediate orthopaedic consultation with surgical intervention as early as two weeks from the date of injury may be considered. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities. The patient should also agree to comply with the pre- and post-operative treatment plan and home exercise requirements and understand the length of partial and full-disability expected post-operatively. With a Type IV-VI AC joint injury, an orthopedic surgical consultation is recommended.

8. Operative Procedures:

a. AC joint stabilization with or without distal clavicle resection. Distal clavicle resection may prevent painful arthritis but can compromise post-operative AC joint stabilization.

9. Post-operative Treatment:

a. An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative.

b. Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening.

i. Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

ii. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

iii. Maximum Duration: 12 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

c. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

10. Adhesive Capsulitis/Frozen Shoulder Disorder

a. Description/Definition: Adhesive capsulitis of the shoulder, also known as frozen shoulder disorder, is a soft tissue lesion of the glenohumeral joint resulting in global restrictions of passive and active ROM. Lack of passive ROM can persist even with therapy, for an average of 30 months. The disorder progresses through stages, specifically:

i. Stage 1 - Consists of acute pain with some limitation in range-of-motion; generally lasting two to nine months.

ii. Stage 2 - Characterized by progressive stiffness, loss of passive range-of-motion, muscular atrophy, and decreased pain; generally lasting an additional 3 to 12 months beyond Stage 1.

iii. Stage 3 - Characterized by partial or complete resolution of symptoms and restoration of ROM and strength; it usually takes an additional 5 to 26 months beyond Stage 2.

iv. Patients will usually complain of pain in the sub-deltoid region, but occasionally over the long head of the biceps or radiating down the lateral aspect of the arm to the forearm. Pain is often worse at night, with difficulty sleeping on the involved side. Motion is restricted and painful.

v. In Stages 2 and 3, patients may also experience peri-scapular and neck pain from compensatory scapular thoracic motion.

vi. Idiopathic adhesive capsulitis usually occurs spontaneously without any specific inciting injury. This occurs most frequently in diabetic, middle aged patients. This type of adhesive capsulitis is likely to remit over time and is usually not work related.

vii. Capsulitis or stiffness may occur secondary to trauma or surgery from another condition. Therapy and additional treatment recommendations for other specific diagnoses should be strictly followed to decrease the occurrence of secondary restricted ROM.

b. Occupational Relationship: There should be some history of work related injury. Occupational adhesive capsulitis may arise secondary to any chest or upper extremity trauma. Primary adhesive capsulitis is rarely occupational in origin.

c. Specific Physical Exam Findings may include: Restricted active and passive glenohumeral ROM in multiple planes is the primary physical finding. It may be useful for the examiner to inject the subacromial space with lidocaine and then repeat ROM testing to rule out stiffness secondary to rotator cuff or bursal pathology. Lack of improvement of ROM usually confirms the diagnosis. Postural changes and secondary trigger points along with atrophy of the deltoid and supraspinatus muscles may be seen.

d. Diagnostic Testing Procedures:

i. Plain x-rays should be done to rule out concomitant pathology such as subluxation or tumor.

ii. Other diagnostic testing may be indicated to rule out associated pathology. Refer to Follow-up Diagnostic Procedures and to Specific Diagnosis, Testing, and Treatment. Dynamic sonography may be useful to specifically identify the movements most affected and rule out other pathology.

iii. Laboratory tests should be considered to rule out systemic diseases.

e. Non-operative Treatment Procedures: Address the goal to restore and maintain function and may include the following:

i. Therapeutic interventions are the mainstay of treatment. They should include ROM, active therapies, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and instruction in a home exercise program targeted to further improve ROM and strength of the shoulder girdle musculature. There is some evidence that a home exercise program will have similar results to fully-supervised physical therapy in non-workers compensation populations; however, to facilitate return to work, supervised therapy is generally recommended for at least several sessions to assure proper performance of home exercise and to evaluate continued progress. These sessions are in addition to any sessions already performed for the original primary related diagnosis. Refer to Therapeutic

Procedures, Non-operative for all other therapies as well as a description of active and passive therapies.

(a). Time to Produce Effect: Four sessions.

(b). Frequency: Two times per week for the first two weeks and one time or less thereafter.

(c). Optimum Duration: 8 to 12 sessions.

(d). Maximum Duration: 20 sessions per year.

Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if therapy to date has demonstrated objective functional gains.

ii. Return to work duties with increased ROM as tolerated are also helpful to increase function. Refer to Return to Work.

iii. Medications, such as NSAIDs and analgesics, may be helpful. Narcotics are indicated for post-manipulation or post-operative cases. Judicious use of pain medications to optimize function may be indicated. Refer to Medications.

iv. Subacromial bursal and/or glenohumeral steroid injections can decrease inflammation and allow the therapist to progress with functional exercise and ROM. There is strong evidence that intra-articular injection of a corticosteroid produces pain relief and increases ROM in the short-term for individuals with restriction of both active and passive ROM in more than one direction. There is good evidence that the addition of a physical therapy or home exercise program is more effective than steroid injections alone. Injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for 2 weeks after injections.

(a). Time to Produce Effect: One injection.

(b). Maximum Duration: Three injections in one year at least four to eight weeks apart, when functional benefits are demonstrated with each injection.

v. There is no clear long-term benefit for suprascapular nerve blocks, however, blocks may be appropriate for patients when pain is not well-controlled and injections improve function.

(a). Time to Produce Effect: One block should demonstrate increased ability to perform exercises and/or range-of-motion.

(b). Maximum Duration: Three per year.

vi. In cases that are refractory to conservative therapy lasting at least three to six months, and in whom ROM remains significantly restricted (abduction usually less than 90 degrees), the following treatment may be considered:

(a). Distension arthrography or "brisement" in which saline, an anesthetic and usually a steroid are forcefully injected into the shoulder joint causing disruption of the capsule. There is good evidence that distension arthrogram with steroid and saline improves function in patients with decreased passive ROM after three months of treatment. Early therapy to maintain ROM, and restore strength and function should follow distension arthrography. Return to work with restrictions should be expected within

one week of the procedure; return to full-duty is expected within four to six weeks.

(b). Dynamic splinting may be appropriate for rare cases when a functional ROM has not been achieved with the treatment listed above.

vii. There is no evidence that hyaluronate injections are superior to physical therapy in this condition and are not recommended.

viii. Other therapies in Therapeutic Procedures, Non-operative, may be employed in individual cases.

f. Surgical Indications: Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after three to six months of active patient participation in non-operative therapy. For most individuals this constitutes limitations in the range of 130 degrees elevation and 120 degrees abduction; with significant functional limitations; however, individuals who must perform overhead work and lifting may require a greater ROM. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities. The patient should also agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

g. Operative Procedures: Manipulation under anesthesia which may be done in combination with steroid injection, distension arthrography, or arthroscopy. Contraindications to closed manipulation under anesthesia include anti-coagulation or bleeding diatheses, significant osteopenia, or recent surgical repair of shoulder soft tissue, fracture or neurological lesion. Complications may include humeral fracture, dislocation, cuff injuries, labral tears or brachial plexus injury. Arthroscopic capsular release or open surgical release may be appropriate in rare cases with failure of previous methods and when the patient has demonstrated ability to follow through with required physical and occupational therapy. Other disorders, such as impingement syndrome, may also be treated at the same time. Radiofrequency is not recommended due to reported complications from chondrolysis.

h. Post-operative Treatment. An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Therapy may include the following:

i. Early therapeutic rehabilitation interventions are recommended to maintain ROM and should progress to strengthening exercises.

ii. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity.

iii. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

iv. Maximum Duration: Up to 12 weeks. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

v. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

vi. Patient should be approaching MMI within 8 to 12 weeks post-operatively; however, co-existence of other pathology should be taken into consideration.

## B. Bicipital Tendon Disorders

### 1. Description/Definition:

a. Disorders may include: primary bicipital tendonopathy, which is exceedingly rare; secondary bicipital tendonopathy, which is generally associated with rotator cuff tendonitis or impingement syndrome (see appropriate diagnosis subsections); subluxation of the biceps tendon, which occurs with dysfunction of the transverse inter-tubercular ligament and rotator cuff tears; and acute disruption of the tendon, which can result from an acute distractive force or transection of the tendon from direct trauma.

b. Symptoms may include aching, burning and/or stabbing pain in the shoulder, usually involving the anterior medial portion of the shoulder girdle. The symptoms are exacerbated with above-the-shoulder activities and those specifically engaging the biceps (flexion at the shoulder, flexion at the elbow and supination of the forearm). Relief occurs with rest. Patients may report nocturnal symptoms which interfere with sleep during the acute stages of inflammation; pain and weakness in shoulder during activities; repeated snapping phenomenon with a subluxing tendon; immediate sharp pain and tenderness along the course of the long head of the biceps following a sudden trauma which would raise suspicions of acute disruption of the tendon; and/or with predominant pain at the shoulder accompanied by referral patterns which may extend pain into the cervical or distal structures, including the arm, elbow, forearm, and wrist.

### 2. Occupational Relationship.

a. Bicipital tendon disorders may include symptoms of pain and/or achiness that occur after repetitive use of the shoulder and/or blunt trauma to the shoulder. Secondary bicipital tendonitis may be associated with prolonged above-the-shoulder activities, and/or repeated shoulder flexion, external rotation and abduction. Acute trauma to the biceps tendon of the shoulder girdle may also give rise to occupational injury of the biceps tendon.

b. Occupational disorders of the biceps tendon may accompany scapulothoracic dyskinesia, rotator cuff injury, AC joint separation, sub deltoid bursitis, shoulder instability or other shoulder pathology. Symptoms should be exacerbated or provoked by work that activated the biceps muscle. Symptoms may be exacerbated by other activities that are not necessarily work related and the physician should explore and report these areas.

3. Specific Physical Exam Findings may include the following:

a. If continuity of the tendon has been lost (biceps tendon rupture), inspection of the shoulder would reveal deformity (biceps bunching/Popeye deformity). It is important to differentiate between distal and proximal tendon rupture, as distal biceps ruptures often require urgent intervention.

b. Palpation demonstrates tenderness along the course of the bicipital tendon.

c. Pain at end range of flexion and abduction as well as with biceps tendon activation.

d. Provocative testing may include the following (a detailed description of the signs and tests is located in initial diagnostic procedures):

i. Yergeson's sign.

ii. Speed's Test.

iii. Ludington's Test.

iv. Diagnostic Testing Procedures:

(a). Plain x-rays include:

(i). Anterior/Posterior (AP) view.

Elevation of the humeral head is indicative of a rotator cuff tear;

(ii). Lateral view in the plane of the scapula or an axillary view determines an anterior or posterior dislocation or the presence of a defect in the humeral head (a Hill-Sachs lesion);

(iii). Axillary view is also useful to demonstrate arthritis and spurs on the anterior inferior acromion; and

(iv). Outlet view determines if there is a downwardly tipped acromion.

(b). Adjunctive testing, such as sonography, or MRI should be considered when shoulder pain is refractory to four to six weeks of non-operative conservative treatment and the diagnosis is not readily identified by standard radiographic and clinical techniques.

#### 4. Non-operative Treatment Procedures:

a. Benefit may be achieved through procedures outlined in Non-operative Treatment Procedures, such as appropriate modalities, limited acute immobilization, exercise and evaluation of occupational workstation. Therapy should emphasize progressive increase in ROM. With increasing motion and pain control, a strengthening program should be instituted.

i. Time to Produce Effect: Four sessions.

ii. Frequency: Two times per week for the first two weeks and one time or less thereafter.

iii. Optimum Duration: 8 to 12 sessions.

iv. Maximum Duration: 20 sessions per year.

b. Medication, such as nonsteroidal anti-inflammatory and analgesics would be indicated. Narcotics are not normally indicated.

c. Biceps tendon sheath or subacromial steroid injections may be therapeutic. Injections under significant pressure should be avoided as the needle may be penetrating the tendon. Injection into the tendon can cause tendon degeneration, tendon breakdown, or rupture. Caution should be used in patients with a clinical suspicion of a partial tear. Injections should be minimized for patients under 30 years of age.

d. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks after injections.

i. Time to Produce Effect: One injection should provide demonstrable functional benefit.

ii. Maximum Duration: Three injections per year at the same site when functional benefits are demonstrated with each injection.

e. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work. By 8 to 11 weeks, with restoration of full-motion, return to full-duty should be anticipated.

f. Other therapies in Therapeutic Procedures, Non-operative, may be employed in individual cases.

#### 5. Surgical Indications:

a. Acute Distal Biceps Tendon Rupture: normally requires urgent surgical repair.

b. Acute Proximal Long Head Biceps Tendon Rupture: active patient participation in non-operative treatment is often successful; however, operative intervention may be indicated for young patients, manual laborers or others who require forceful supination regularly for their work.

c. Bicipital Tendonitis: Conservative care prior to potential surgery must address flexibility and strength imbalances. Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after 12 weeks of active patient participation in non-operative therapy.

d. Subluxing Bicipital Tendon: Most patients with this condition also have a subscapularis tear. Surgical stabilization of the bicipital tendon is not commonly indicated. Good outcome may be achieved through successful rehabilitation procedures. Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after 12 weeks of active patient participation in non-operative therapy.

e. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

#### 6. Operative Procedures:

a. Distal Biceps tendon repair.

b. Repair of rotator cuff pulley lesion.

c. Proximal tenodesis or tenotomy: Impingement of the biceps tendon can cause continued irritation, and pain preventing shoulder elevation. Tenodesis or tenotomy has been used for decreased elevation after therapy in conjunction with a sub scapular repair or irreparable rotator cuff tear.

#### 7. Post-operative Treatment:

a. An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Therapy may include the following:

b. It is reasonable to restrict ROM for two months for tenodesis or distal biceps tendon repair. Early loading of the tendon should be avoided. Surgical patients may not recover sufficiently to perform full activity for 3 to 12 months. Rehabilitation, lasting at least 6 to 12 weeks, is necessary to facilitate Maximum Medical Improvement (MMI).

i. Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

ii. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

iii. Maximum Duration: 12 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

c. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

C. Brachial Plexus and Shoulder Peripheral Nerve Injuries. Injuries to the brachial plexus and nerves of the shoulder girdle region may result in loss of motor and sensory function, pain, and instability of the shoulder. Signs and symptoms vary with the degree and mechanism of injury. The two modes of injury are: acute direct or indirect traumatic injuries to the shoulder region, and repetitive motion or overuse. Transient compression, stretch or traction (neurapraxia) causes sensory and motor signs lasting days to weeks. Damage to the axon (axonotmesis) without disruption of the nerve framework may cause similar symptoms. The recovery time is delayed and depends upon axon re-growth distally from the site of injury. Laceration or disruption of the entire nerve with complete loss of framework (neurotmesis) is the most severe form of nerve injury and will invariably require surgical intervention. Return of function is dependent upon re-growth of the nerve distal to the injury site. Full return of motor function is variable and may take up to 18 months or longer. Electromyography (EMG) is the most commonly used diagnostic modality to analyze nerve injuries. Electrophysiologic studies, such as electromyography and nerve conduction studies are generally accepted, well-established and widely used for localizing the source of neurological symptoms. These studies should be utilized as an extension of the history and clinical examination and to assess or monitor nerve recovery. Studies should be performed three to four weeks following injury or description of symptoms. Studies performed early may be falsely negative and usually require repeat testing three to four weeks after the original injury. Thus, early testing is not generally recommended. If the symptoms have been present for longer than three to four weeks, studies may be performed immediately after the initial evaluation. Serial studies may be indicated if initial studies are negative and may also be useful for gauging prognosis. Limb temperature should be controlled at 30 to 40 degrees centigrade. A description of six common nerve injuries to the shoulder girdle and their treatment follow.

1. Brachial Plexus Injuries:

a. Description/Definition:

i. The Brachial Plexus is formed by the nerve roots of C5-C8 and T1. These nerve roots exit the cervical spine and pass through the scalene musculature. After leaving the scalene musculature, at the level of the clavicle, they form trunks, division and chords which ultimately form the peripheral nerves of the arm.

b. Occupational Relationship: Direct injury to brachial plexus results in widespread sensory and motor loss. Direct trauma, subluxation to shoulder, clavicular fractures, shoulder depression, or head deviation away from the arm may result in variable brachial plexus lesions. Weight-lifting and carrying heavy back packs have also been associated

with plexus injuries. Most injuries involve the upper and/or lower trunks. Upper trunk plexopathies may accompany full-thickness rotator cuff tears. Isolated middle trunk involvement is rare. Infraclavicular brachial plexus injuries have been reported due to hematoma formation secondary to an axillary block. If this occurs, emergency evacuation of the hematoma may be indicated. Symptoms may appear hours-to-days after the Procedure. Severe motor and sensory axonal loss is frequently seen on electrodiagnostic studies. It is important to differentiate injuries to the brachial plexus from the acquired (non work-related) Parsonage-Turner Syndrome or neuralgic amyotrophy occurring without a history of trauma. This idiopathic syndrome begins with severe pain in the shoulder girdle and is accompanied by resistance to passive motion. As the pain decreases, severe, near total weakness of one or more shoulder girdle muscles occurs. Almost total recovery can be expected but occurs over two to three years.

c. Specific Physical Exam Findings may include:

i. Evidence of trauma or deformity;

ii. Identification of sensory loss and demonstration of weakness which relates to the severity and anatomy of the injury to the brachial plexus; and/or

iii. Pain with recreation of the motions related to the mechanism of injury.

iv. Diagnostic Testing Procedures:

(a). EMG may show acute or chronic denervation of specific nerves. Nerve Conduction Studies demonstrating a loss of amplitude of 50 percent compared to the normal side are considered abnormal. NCVs/EMGs will be repeated at appropriate intervals to assess reinnervation.

(b). If studies do not localize and give sufficient information, then additional information may be obtained from MRI and/or myelography. These studies are employed to differentiate root avulsion from severe brachial plexus injuries. Occasionally MRI may reveal the presence of an unexpected mass lesion consistent with a tumor.

v. Non-operative Treatment Procedures:

(a). In closed injuries, observation is favored. Repeat electrophysiologic studies may be helpful to assess or monitor recovery.

(b). Rehabilitation is based on procedures set forth Non-operative Treatment Procedures. However, utilization of ultrasound, and cold and heat should be discussed with the primary care physician, since these modalities may aggravate nerve injury.

(c). Medications such as analgesics, nonsteroidal anti-inflammatories, anti-depressants and anti-convulsants are indicated and narcotics may be indicated acutely. All medications should be prescribed as found in Thoracic Outlet Syndrome Guidelines.

(d). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

vi. Surgical Indications:

(a). In open injuries, acute exploration may be indicated if nerve discontinuity is visualized. Surgery may be considered post-injury when functional deficits interfere with activities of daily living and/or job duties after active participation in non-operative therapy.

(b). In closed injuries, if functional deficits continue to be documented after three to four months of

active patient participation in non-operative therapy, then exploration may be warranted and a surgical consultation should be considered. Patients with progressive weakness or a loss of function post-injury should be referred for surgical consultation immediately.

vii. Operative Procedures.

(a). Exploration and Repair.

viii. Post-operative Treatment.

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following:

(b). Early therapeutic rehabilitation interventions are recommended to maintain range-of-motion (ROM) and progressive strengthening.

2. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

3. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

4. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

a. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

b. Axillary Nerve:

i. Description/Definition: This nerve is derived from the fifth and sixth cervical roots and passes around the shoulder, supplying motor branches to the teres minor and the three heads of the deltoid. The axillary nerve provides sensation to the top of the shoulder at the level of the deltoid.

5. Occupational Relationship: Direct injury and penetrating wounds to the shoulder and upward pressure on the axilla can cause injury to the axillary nerve. Blunt trauma to the anterolateral shoulder has also been reported. Abnormalities of the nerve can be seen with fractures of the surgical neck of the humerus and dislocation of the shoulder. Axillary nerve injury may also occur from shoulder surgery. Patients complain of reduced abduction of overhead strength and/or numbness in the lateral arm. The quadrilateral space syndrome may cause pain in the axillary nerve region with abduction, external rotation, and extension. The axillary nerve and the posterior circumflex artery are in the space bound by the long head of the triceps, the teres minor, subscapularis, and latissimus dorsi when the arm is abducted. This syndrome is most commonly reported in young males 20 to 40 years of age and has been associated with overhead sports.

6. Specific Physical Exam Findings may include:

a. weakness and atrophy of the deltoid muscle and teres minor;

b. strength is lost in abduction, flexion and extension of the shoulder; and/or

c. sensory loss is reported over the upper arm.

7. Diagnostic Testing Procedures.

a. Plain x-rays.

b. EMG and Nerve Conduction Studies three weeks after the injury and repeated at appropriate intervals to assess for reinnervation. Comparison of EMG and NCV findings

with the opposite side is usually necessary to diagnose the degree of injury.

c. MRI may be done to rule out other pathology.

d. To confirm quadrilateral space syndrome, an MRI angiogram may be done to visualize the posterior circumflex artery occlusion in abduction. However, occlusion is present in 80 percent of normals also. This study should only be done after conservative therapy and if surgery is being contemplated.

8. Non-operative Treatment Procedures:

a. Rehabilitation is based on procedures set forth in Non-operative Treatment Procedures. However, utilization of ultrasound, and cold and heat should be discussed with the primary care physician since these modalities may aggravate the nerve injury. Shoulder range-of-motion should be emphasized. For quadrilateral space syndrome, stretching of the posterior shoulder and teres minor is recommended.

b. Medications such as analgesics, nonsteroidal anti-inflammatory, anti-depressants and anti-convulsants are indicated. Narcotics may be indicated acutely. All medications should be prescribed as described in Thoracic Outlet Syndrome Guidelines.

c. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

9. Surgical Indications: Surgical procedures are usually not necessary, since most injuries to the axillary nerve are due to stretch and/or traction and recover within three to six months. Even when deltoid weakness persists, return to full activity can be expected. One may consider surgery when functional deficits interfere with activities of daily living and/or job duties after three to four months of active patient participation in non-operative therapy and with EMG/NCV documentation of ongoing denervation and loss of function. Lesions secondary to direct penetrating trauma or previous surgery may require more immediate intervention. Surgery for quadrilateral space syndrome is not usually necessary as at least 70 percent of patients recover with conservative treatment. Indications may include six months of conservative treatment with persisting functional deficits, a positive arteriogram, and point tenderness at the posterior quadrilateral space. Overall outcomes of surgery cannot be predicted, as only a small case series have been reported.

10. Operative Procedures:

a. Exploration and Repair.

11. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following: Early therapeutic rehabilitation interventions are recommended to maintain range-of-motion (ROM) and progressive strengthening.

a. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

b. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

c. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce

exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

d. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

e. Long Thoracic Nerve.

12. Description/Definition:

a. The long thoracic nerve is formed by the cervical fifth, sixth, and seventh roots; it crosses the border of the first rib and descends along the posterior surface of the thoracic wall to the serratus anterior.

13. Occupational Relationship:

a. Injury can occur by direct trauma to the posterior triangle of the neck or trauma may be the result of chronically repeated or forceful shoulder depression. Repeated forward, overhead motion of the arms with the head tilted or rotated to the unaffected side, as well as, stretch or compression of the nerve with the arms abducted, can lead to long thoracic nerve dysfunction. Occasionally, severe traction with the shoulder compressed and the head tilted may be associated with long thoracic nerve pathology.

14. Specific Physical Exam Findings may include:

a. dull ache in the region of the shoulder exacerbated by tilting the head away from the effected side and without sensory loss;

b. scapular deformity and/or winging may be described by patient or family; and/or

c. serratus anterior wasting; and

d. scapular winging at the inferior border that may be demonstrated by asking the patient to forward elevate and lean on his arms, such as against a wall and/or the examiner resisting protraction. (Spinal accessory nerve pathology also causes winging when the patient is abducting.)

15. Diagnostic Testing Procedures.

a. Plain x-rays.

b. EMG and Nerve Conduction Studies three weeks after the injury and repeated at appropriate intervals to assess for reinnervation. Comparison of EMG and NCV findings with the opposite side is usually necessary to diagnose the degree of injury. Studies may also exclude more widespread brachial involvement.

c. MRIs or CTs if there is a need to rule out other pathology.

16. Non-operative Treatment Procedures.

a. Rehabilitation is based on procedures set forth in Non-operative Treatment Procedures. Utilization of ultrasound, cold, and heat should be discussed with the Primary Care Physician since these modalities can aggravate nerve injury. Strengthening of the scapular stabilizers should be stressed.

b. Orthotics may be used to stabilize the scapula but long-term benefit is not established.

c. Medications such as analgesics, nonsteroidal anti-inflammatory, anti-depressants and anti-convulsants are indicated and narcotics may be indicated acutely. All medications should be prescribed as seen in Thoracic Outlet Syndrome Guidelines.

d. Return to work with appropriate restrictions should be considered early in the course of treatment (Refer to Return to Work). Heavy lifting and other activities that might stress the nerve should be avoided.

17. Surgical Indications. Laceration of the nerve and progressive loss of function are indications for prompt surgical intervention. Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after four to six months of active participation in non-operative therapy. Surgical consultation should occur at three to four months post-injury for these patients. In most cases, function will recover with conservative therapy in 6 to 12 months.

18. operative Procedures:

a. exploration and Repair.

b. muscle transfer.

c. scapular fixation.

19. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following: Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening focusing on the scapular stabilizers.

a. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

b. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

c. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

d. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

e. Musculocutaneous Nerve.

D. Description/Definition: The nerve is derived from the fifth and sixth cervical roots. It innervates the coracobrachialis, biceps and brachioradialis muscles and also provides sensation to the lateral aspect of the forearm.

E. Occupational Relationship: Trauma (including surgery) or penetrating wound to the brachial plexus, coracobrachialis, and shoulder often can cause nerve injury. Most commonly, a stretch/traction injury with the arm in abduction and external rotation induces nerve dysfunction. Cases have been reported to be associated with backpack use, pitching, heavy weight-lifting, mal-position during sleep or surgery, and sudden, forceful extension of the elbow. Complaints may include pain from the axilla into the forearm, biceps weakness, or sensation changes to the lateral forearm from the lateral antebrachial cutaneous nerve.

1. Specific Physical Exam Findings may include:

a. Weakness and atrophy in the biceps and brachialis; and/or

b. Sensory loss over the lateral aspect of the forearm; however, this is not always seen.

2. Diagnostic Testing Procedures.

a. EMG and Nerve Conduction Studies three weeks after the injury and repeated at appropriate intervals to assess for reinnervation. Comparison of EMG and NCV findings with the opposite side is usually necessary to diagnose the degree of injury.

3. Non-operative Treatment Procedures.

a. Rehabilitation is based on procedures set forth in Section F, Non-operative Treatment Procedures. Utilization of ultrasound, cold and heat should be discussed with the primary care physician, since these modalities can aggravate nerve injury.

b. Medications such as analgesics, nonsteroidal anti-inflammatory, anti-depressants and anti-convulsants are indicated and narcotics may be indicated acutely. All medications should be prescribed as seen in Thoracic Outlet Syndrome Guidelines.

c. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

4. Surgical Indications: Laceration of the nerve and progressive loss of function are indications for prompt surgical intervention. Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after four to six months of active patient participation in non-operative therapy. Surgical consultation should occur at three to four months post-injury for these patients. In most cases, function will recover with conservative therapy in 6 to 12 months.

5. Operative Procedures.

a. Exploration and Repair.

6. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following: Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening.

a. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

b. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

c. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

d. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

e. Spinal Accessory Nerve:

i. Description/Definition: Spinal Accessory Nerve is the eleventh cranial nerve innervating the ipsilateral sternocleidomastoid and trapezius muscles which are extremely important for scapular control and ultimately shoulder function.

ii. Occupational Relationship: Direct trauma to the posterior neck, forceful compression of the shoulder downward, and/or deviation of the head away from the traumatized shoulder can lead to injury to this nerve such as from a fall or motor vehicle accident. Surgical resection of the posterior neck can disrupt the nerve. Patients complain of inability to fully elevate or abduct above horizontal.

7. Specific Physical Exam Findings may include:

a. pain in the shoulder;

b. asymmetrical neckline;

c. scapular winging with the arms out to the side, abduction, or with external rotation;

d. weakness or paralysis of the trapezius with weakness in forward flexion or abduction above 90 degrees; and/or

e. drooping of the shoulder.

8. diagnostic Testing Procedures:

a. EMG and Nerve Conduction Studies three weeks after the injury and repeated at appropriate intervals to assess for reinnervation. Comparison of EMG and NCV findings with the opposite side is usually necessary to diagnose the degree of injury.

b. Radiographic procedures may be necessary to exclude lesions at the base of the brain or upper cervical spine.

9. Non-operative Treatment Procedures.

a. Rehabilitation is based on procedures set forth in Non-operative Treatment Procedures. Utilization of ultrasound, cold and heat should be discussed with the Primary Care Physician, since these modalities can aggravate nerve injury. Resistance exercises to strengthen muscles. Braces may be used but probably have no long-term value.

b. Occupational work station will usually need significant modification due to inability to work above 90 degrees flexion or abduction. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

c. Medications such as analgesics, nonsteroidal anti-inflammatory, anti-depressants and anti-convulsants are indicated and narcotics may be indicated acutely. All medications should be prescribed as seen in Thoracic Outlet Syndrome Guidelines.

10. Surgical Indications: Laceration of the nerve and progressive loss of function are indications for prompt surgical intervention. Surgery may be considered when functional deficits interfere with activities of daily living and/or job duties after four to six months of active participation in non-operative therapy. Surgical consultation should occur at three to four months post-injury for these patients. In most cases, function will recover with conservative therapy in 6 to 12 months.

11 Operative Procedures.

a. exploration and repair;

b. tendon transfer – Trapezius, levator scapular, rhomboids;

c. scapular fixation for cases with heavy work demands and failed previous procedures.

12. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following:

a. Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening focusing on scapula stabilizers.

i. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

ii. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

iii. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce

exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

iv. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

vi. Suprascapular Nerve.

(a). Description/Definition. This nerve is derived from the fifth and sixth cervical root, superior trunk of the brachial plexus and it innervates the supraspinatus and infraspinatus muscles of the rotator cuff.

(b). Occupational Relationship. Supraclavicular trauma, stretch, and friction through the suprascapular notch or against the transverse ligament at the notch, or a fall on an outstretched arm can cause injury to the nerve. Repetitive use of the arm has been shown on occasion to cause traction to the nerve. Damage, may occur secondary to a ganglion cyst which usually causes infraspinatus atrophy. Ganglion cysts may be associated with labral pathology and/or rotator cuff tears. These are most commonly reported in athletes. Up to one third of volley ball players in one study had asymptomatic infraspinatus atrophy secondary to nerve damage. Nerve damage may also occur associated with a full rotator cuff tear. Since the clinical findings are similar for both diagnoses, clinicians should always consider the possibility of nerve damage when atrophy accompanies a rotator cuff tear.

(c). Specific Physical Exam Findings may include:

- (i). pain at the shoulder;
- (ii). wasting at the supraspinatus and/or infraspinatus muscles with weakness of external rotation and abduction with overhead activity; and/or
- (iii). a positive Tinel's eliciting a provocative pain response.

(d). Diagnostic Testing Procedures:

(i). EMG and Nerve Conduction Studies three weeks after the injury and repeated at appropriate intervals to assess for reinnervation. Comparison of EMG and NCV findings with the opposite side is usually necessary to diagnose the degree of injury.

(ii). If one suspects a mass lesion at the suprascapular notch or related labral or cuff pathology then an MRI or sonography may be indicated.

(iii). CT scan with attention to the suprascapular notch may be used to evaluate for boney impingement.

(e). Non-operative Treatment Procedures:

(i). Resolution of symptoms usually occurs within 6 to 12 months of diagnosis with non-operative treatment in the absence of lesions such as a cyst.

(ii). Rehabilitation is based on procedures set forth in Non-operative Treatment Procedures. An emphasis should be placed on posture; maintaining full shoulder motion; strengthening; and stretching the posterior capsule. Utilization of ultrasound, cold and heat should be discussed with the primary care physician, since these modalities can aggravate nerve injury.

(iii). Medications such as analgesics, nonsteroidal anti-inflammatory, anti-depressants, and anti-convulsants are indicated and narcotics may be indicated

acutely. All medications should be prescribed as seen in Thoracic Outlet Syndrome Guidelines.

(iv). Return to work with appropriate restrictions should be considered early in the course of treatment (Refer to Return to Work). Heavy lifting or activities that aggravate the condition should be avoided.

13. Surgical Indications: Surgical release is warranted depending upon the presence of a ganglion cyst, results of the electrophysiologic studies, and/or absence of improvement with conservative management. In cases without cysts or other operative diagnoses, non-operative treatment may be tried for three to six months due to the observed recovery rate of cases with no treatment. Difficulty performing functional activities after active patient participation should be the deciding factor. [General Principles]

14. Operative Treatment Procedures.

a. decompression and/or excision of ganglion cyst; and/or labral repair;

b. surgical release at the suprascapular notch or spinoglenoid region;

15. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Treatment may include the following: Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening.

a. Frequency: Suggested frequency pattern is three to five times per week for the first two weeks. Three times per week for the following two weeks, then one to two times per week. The exact frequency per week will depend on the severity and level of the nerve injury.

b. Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

c. Maximum Duration: Up to 24 sessions. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

d. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

F. Bursitis/Rotator Cuff Tendinopathy (Alternate Spelling "Tendinopathy") of the Shoulder

1. Description/Definition.

a. Bursitis: Acute or chronic inflammation of the bursa (a potential fluid filled sac) that may be caused by trauma, chronic overuse, inflammatory arthritis, and acute or chronic infection, and generally presents with localized pain and tenderness of the shoulder.

b. Tendinopathy includes the terms tendonitis, an inflammation of the tendon and tendonosis, non-inflammatory degenerative processes.

c. Rotator cuff tendinopathy may involve one or more of the four musculotendinous structures arising from the scapula and inserting on the lesser or greater tuberosity of the humerus may be involved. These structures include one internal rotator (subscapularis), and two external rotators (infraspinatus and teres minor), and the supraspinatus which assists in abduction.

d. History may include nocturnal pain, pain with over-the-shoulder activities, feeling of shoulder weakness

and specific limitations of movement. Prior treatment for presenting complaint(s) and pertinent familial history should be obtained.

2. Occupational Relationship: Onset of symptoms, date, mechanism of onset, and occupational history and current job requirements should be correlated with the intensity, character, duration and frequency of associated pain and discomfort. Tendonopathy may include symptoms of pain and/or achiness that occur after blunt trauma or repetitive use of the shoulder. Bursitis is often a sequela of an occupational strain or tendonopathy in the absence of other mitigating factors.

3. Specific Physical Exam Findings may include:

a. Palpation elicits localized tenderness over the particular bursa or inflamed tendon with loss of motion during activity;

b. Painful arc may be seen between 40 and 120 degrees; and/or

c. Bursitis may be associated with other shoulder injury diagnoses such as impingement, rotator cuff instability, tendonitis, etc.; refer to applicable diagnosis subsections for additional guidelines.

4. Diagnostic Testing Procedures:

a. Plain x-rays include:

5. AP view. Elevation of the humeral head indicates rotator cuff tear;

6. Lateral view in the plane of the scapula or an axillary view determines if there is anterior or posterior dislocation, or the presence of a defect in the humeral head (a Hill-Sachs lesion);

7. Axillary view is also useful to demonstrate arthritis and spurs on the anterior inferior acromion;

8. Outlet view determines if there is a downwardly tipped acromion.

a. Lab Tests. Laboratory tests may be used to rule out systemic illness or disease when proper clinical presentation indicates the necessity for such testing. Testing may include sedimentation rate, rheumatoid profile, complete blood count (CBC) with differential, and serum uric acid level. Routine screening for other medical disorders may be necessary, as well as, bursal aspiration with fluid analysis.

b. The subacromial injection has generally been considered the gold standard for differentiating ROM loss from impingement versus rotator cuff tears. Alleviation from pain may help to confirm the diagnosis. Patients with impingement should recover normal strength after the injection, while those with rotator cuff tears usually do not recover normal strength. However, manually tested elevation strength perceived as normal does not always rule out rotator cuff tear and this may contribute to incorrect diagnoses with this technique. There is good evidence that blinded subacromial blocks are not accurate. Up to a third of blinded injections may involve the cuff, and are likely to cause pain. This may lead to an incorrect diagnosis. One study demonstrated that at least half of the positive responders did so up to 40 minutes after the injection; therefore, a negative response should not be diagnosed until 40 minutes post injection. The inaccuracy of the injection and patient response in some cases may contribute to its inability to completely predict the amount of recovery from subacromial decompression.

c. If there is a concern regarding needle placement, sonography or fluoroscopy may be used.

d. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks after injections.

9. Non-operative Treatment Procedures:

a. Therapeutic interventions are the mainstay of treatment. They should include ROM, active therapies, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and instruction in a home exercise program targeted to further improve ROM and strength of shoulder girdle musculature. Refer to Therapeutic Procedures, Non-operative.

b. May return to work without overhead activities and lifting with involved arm. An evaluation of the occupational work being performed and the work station may be necessary to institute ergonomic changes or accommodations. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

c. Medications such as oral nonsteroidal anti-inflammatory, oral steroids and analgesics.

d. Steroid injections may be therapeutic. Injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause possible tendon breakdown, tendon degeneration, or rupture. Injections should be minimized for patients under 30 years of age.

i. Time to Produce Effect: One injection.

ii. Maximum: three injections at the same site per year when functional benefits are demonstrated with each injection.

iii. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks after injections.

e. Other therapies outlined in Therapeutic Procedures, Non-operative, may be employed in individual cases.

10. Operative Procedures: Are not commonly indicated for bursitis or tendonopathy. Refer to other related diagnoses in Specific Diagnosis Testing and Treatment Procedures.

11. Calcifying Tendinitis

a. Description/Definition:

i. Calcifying tendonitis is characterized by the deposition of hydroxyapatite (calcium phosphate) in any tendon of the rotator cuff. The supraspinatus tendon is affected most frequently. It is a morphologic diagnosis which may be asymptomatic or may produce pain. It may be present in a painful shoulder without being the cause of the pain. Radiographically evident calcifications are present without producing symptoms in some adults (7.5 percent to 20 percent). The calcifying process occurs in two phases: the formative phase, in which calcium deposits coalesce in the tendon matrix, and the resorptive phase, in which the calcium deposits are removed by phagocytic cells. The resorptive phase is thought to be the painful phase of the disorder. The etiology is not known, but trauma is considered unlikely to be causative. Pain may be accompanied by loss of ROM, a painful arc of motion, or by

impingement signs. Morphologic classification of calcium deposits is based on the homogeneity and borders of the deposit on plain x-ray. (Gartner and Simons Classifications) Type I is homogenous with well-defined borders. Type II is heterogeneous in structure with sharp outline or homogenous in structure with no defined border. Type III is cloudy and transparent with no well-defined border. Type III frequently resolves without treatment. Generally, they are not associated with rotator cuff tears. The size of the deposit has not been shown to be correlated with severity of symptoms.

b. Occupational Relationship. Symptomatic calcifying tendonitis may occur after repetitive loading of the shoulder with force, such as with shoveling, raking, pushing, pulling, lifting at/or above shoulder level, or after blunt trauma to the shoulder.

c. Specific Physical Exam Findings may include:

i. pain with palpation to the shoulder with active or passive abduction and external rotation of the shoulder (painful arc);

ii. pain with specific activation of the involved muscles; and/or

iii. pain with impingement signs;

iv. severe pain on examination in some cases.

d. Diagnostic Testing Procedures:

i. plain x-ray films including AP lateral, axial, 30 degrees caudally angulated AP, Outlet view.

ii. If shoulder pain is refractory to 4 to 6 weeks of non-operative care and other diagnoses are suspected, adjunctive testing, such as MRI, sonography or arthrography, may be indicated.

e. Non-operative Treatment Procedures

i. Therapeutic rehabilitation interventions are the mainstay of treatment. They should include ROM, active therapies, and a home exercise program. Passive as well as active therapies may be used for pain control, including iontophoresis. Therapy should progress to strengthening and instruction in a home exercise programs targeted to ongoing ROM and strengthening of shoulder girdle musculature. Refer to Therapeutic Procedures, Non-operative for other therapies as well as a description of active and passive therapies.

ii. Medications such as oral nonsteroidal anti-inflammatories, analgesics, and narcotics for significant pain. Refer to Medications.

iii. May return to work without overhead activities and lifting with involved arm. An evaluation of the occupational work station may be necessary to institute ergonomic changes or accommodations. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

iv. Therapeutic ultrasound (Refer to Passive Therapy) may be used for tendonitis. There is some evidence that ultrasound alleviates symptoms, improves function, and reduces calcium deposits better than sham ultrasound in the short term. The advantage of ultrasound beyond six weeks is not certain.

v. Ultrasound-guided needle lavage and aspiration requires a physician skilled in sonographic techniques and is still considered investigational due to lack of randomized controlled trials. It is less costly and reportedly less painful than extracorporeal shock wave therapy. It requires prior authorization but may be an

appropriate therapy in select patients who fail other conservative treatment.

vi. Extracorporeal shock wave therapy has good evidence for improving pain and function with calcifying tendonitis Type I or II when conservative treatment has not resulted in adequate functional improvement (See ESWT). General anesthesia or conscious sedation is not required for this procedure. Patients should be cautioned regarding the potential of avascular necrosis.

vii. Steroid injections may be therapeutic. Injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause tendon degeneration, tendon breakdown, or rupture. Injections should be minimized for patients under 30 years of age.

(a). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks after injections.

(i). Time to Produce Effect: One injection.

(ii). Maximum: Three injections at the same site per year when functional benefits are demonstrated with each injection.

viii. Other therapies outlined in Therapeutic Procedures, Non-operative, may be employed in individual cases.

f. Surgical Indications. When functional deficits interfere with activities of daily living and/or job duties after three to four months of active patient participation in non-operative therapy. The natural history of calcifications includes resorption over time, with or without therapy. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities. The patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

g. Operative Procedures: Either an arthroscopic or open procedure may be used. Careful lavage to remove all calcium deposits from the surgical field is important. Full recovery may vary from three to six months.

h. Post-operative Treatment. Individualized rehabilitation programs are based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Treatment may include the following:

i. Sling, pillow sling, or abduction splint;

ii. Gentle pendulum exercise, passive glenohumeral range-of-motion and posterior scapular stabilizing training can be instituted;

iii. Patients can judiciously return to activities as tolerated per physician recommendations. If there is a significant tendon repair, progression will be delayed;

iv. Progressive resistive exercise program beginning at two months with gradual returning to full activity at 4 to 6 months; all active non-operative procedures listed in Non-operative Treatment Procedures should be considered.

(a). Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

(b). Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

(c). Maximum Duration: 12 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

v. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon. Depending upon the patient's functional response and their job requirements, return to work with job modifications may be considered as early as one week post-operatively. The employer must be able to fully accommodate restrictions of overhead activities or heavy lifting. Physician/surgeon should be very specific regarding restrictions for overhead activities and heavy lifting. Work restrictions should be evaluated every four to six weeks during post-operative recovery and rehabilitation, with appropriate written communications to both the patient and the employer. Should progress plateau, the provider should re-evaluate the patient's condition and make appropriate adjustments to the treatment plan.

12. Fractures. There are five common types of shoulder fractures; each type will be addressed separately and in the order of most frequent occurrence.

a. Clavicular Fracture:

i. Occupational Relationship: Can result from direct blows or axial loads applied to the upper limb; commonly associated injuries include rib fractures, long-bone fractures of the ipsilateral limb and scapulothoracic dislocations.

ii. Specific Physical Exam Findings may include:

(a). Pain along the clavicle;

(b). Abrasions on the chest wall, clavicle and shoulder;

(c). Deformities in the above regions; and/or

(d). Pain with palpation and motion at the shoulder joint area.

iii. Diagnostic Testing Procedures: Clavicle x-rays. If they do not reveal sufficient information, then a 20 degree caudal-cranial AP view centered over both clavicles can be done.

iv. Non-operative Treatment Procedures:

(a). Most are adequately managed by closed techniques and do not require surgery. After reduction, the arm is immobilized in a sling or figure-8 bandage. Shoulder rehabilitation is begun with pendulum exercises 10 to 14 days after injury. Subsequently, with pain control, the therapy program can be progressed with therapeutic approaches as indicated in Non-operative Treatment Procedures.

(b). Medication, such as analgesics and nonsteroidal anti-inflammatories, would be indicated; narcotics may be indicated acutely for fractures and should be prescribed as indicated in Medications.

(c). All patients with fractures, especially those over 50, should be encouraged to ingest at least 1200 mg of Calcium and 800 IU of Vitamin D per day. There is some evidence that, for women in the older age group (58 to 88) with low hip bone density, greater callus forms for those who adhere to these recommendations than those who do not. Although the clinical implications of this are not known,

there is greater non-union in this age group and thus, coverage for these medications during the fracture healing time period is recommended. At this time there is no evidence that bisphosphonates increase acute fracture healing.

(d). All female patients over 65 should be referred for an osteoporosis evaluation. Patients who have been on prednisone at a dose of 5 to 7.5 mg for more than three months should be evaluated for glucocorticoid induced osteoporosis. An osteoporosis evaluation may be considered for males who: are over 70, are physically inactive, have previous fragility fracture, have a BMI less than 20, or have been hypogonadal for five years. Evaluation may also be considered for patients on medications that can cause bone loss, patients who have suffered a fracture due to a low-impact fall or with minimum to no provocation, and women under 65 with one of the following: menopause before 40, current smoker, or body mass index less than 20. Low body weight appears to be the best predictor of osteoporosis in women younger than 65. In one adequate study, all patients aged 50 to 75 referred to an orthopaedic department for treatment of wrist, vertebral, proximal humerus, or hip fractures received bone mass density testing. 97 percent of patients had either osteoporosis (45 percent) or osteopenia (42 percent). Referral is important to prevent future fractures in these groups. Long-term care for osteoporosis is not covered under workers compensation even though it may be discovered due to an injury-related acute fracture.

(e). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

(f). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

v. Surgical Indications: Open fractures, vascular or neural injuries requiring repair, bilateral fractures, ipsilateral scapular or glenoid neck fractures, scapulothoracic dislocations, flail chest and non-union (displaced-closed fractures that show no evidence of union after four to six months). A Type II fracture/dislocation at the AC joint where the distal clavicular fragment remains with the acromion and the coracoid, and the large proximal fragment is displaced upwards is another indication for surgery. Completely displaced midclavicular fractures may be an indication for surgical repair. There is some evidence that plate fixation of completely displaced fractures involving the middle third of the clavicle leads to slightly better shoulder function than immobilization without surgical fixation and shorter healing time. Conservatively treated completely displaced fractures heal with mild decreases in strength and good patient satisfaction in 70 percent or more of cases. However, initial surgical repair may be considered for patients who desire excellent shoulder function for sport or job activities and/or those with approximately two cm or greater shortening of the clavicle. Because smokers have a higher risk of non-union and post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

vi. Operative Procedures: Repair of fracture or associated distal clavicular resection using plates and screws or an intramedullary device.

vii. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with two to three weeks of rest with a shoulder immobilizer while encouraging isometric deltoid strengthening. Pendulum exercises with progression to assisted forward flexion and external rotation would follow. Strengthening exercises should be started at 10 to 12 weeks as indicated in Non-operative Treatment Procedures.

viii. Bone-Growth Stimulators

(a). Electrical: Preclinical and experimental literature has shown a stimulatory effect of externally applied electrical fields on the proliferation and calcification of osteoblasts and periosteal cells. Ensuing clinical literature on electrical stimulation of bone fractures has principally focused on the spine and lower extremity. Several techniques have been developed to deliver an electrical stimulus to a fracture or osteotomy site. Nonsurgical techniques include Capacitive Coupling (CC), which places skin electrodes on opposite sides of the bone being treated. Pulsed Electromagnetic Field (PEMF) uses a current-carrying coil which induces a secondary electrical field in bone. High-quality literature of electrical bone growth stimulation are lacking for shoulder injuries. Literature is conflicting in the use of electrical stimulation in other regions of the body. Due to a lack of supporting scientific evidence, it requires prior authorization and may be only considered when conventional surgical management has failed.

(b). Low-intensity Pulsed Ultrasound: There is some evidence that low-intensity pulsed ultrasound, applied by the patient at home and administered as initial treatment of the fracture, reduces the time required for cortical bridging in certain fractures of bones outside the shoulder joint. Shoulder fractures were not included in this literature. Non-union and delayed unions were not included in these clinical trials. Possible indications for Low-Intensity Pulsed Ultrasound are non-unions or fractures that are expected to require longer healing time. Prior authorization is required.

b. Proximal Humeral Fractures: Fractures of the humeral head have been classically described using Neer criteria; however, literature has shown a low level of observer agreement. These fractures are commonly referred to as one, two, three or four part fractures based on the number of fracture fragments. Displaced fractures of the greater tuberosity and impacted angulated fractures of the humeral head also have specific associated problems.

i. Occupational Relationship: May be caused by a fall onto an abducted arm; high-energy (velocity or crush) trauma with an abducted or non-abducted arm. Associated injuries are common, such as glenohumeral dislocation; stretch injuries to the axillary, musculocutaneous, and radial nerves; and axillary artery injuries with high-energy accident.

ii. Specific Physical Exam Findings may include:

- (a). pain in the upper arm;
- (b). swelling and bruising in the upper arm, shoulder and chest wall;
- (c). abrasions about the shoulder; and/or
- (d). pain with any attempted passive or active shoulder motion.

iii. Diagnostic Testing Procedures:

(a). X-ray trauma series (three views) are needed; AP view, axillary view and a lateral view in the plane of the scapula. The latter two views are needed to determine if there is a glenohumeral dislocation. When an axillary view cannot be obtained, a CT should be done to rule out posterior dislocation.

(b). Vascular studies are obtained emergently if the radial and brachial pulses are absent.

(c). Classification can be by the Neer Method, however, agreement between observers using this method is poor. There are four fragments: the humeral shaft, humeral head, greater tuberosity, and the lesser tuberosity. The fragments are not usually considered fragments unless they are separated by 1 cm or are angulated 45 degrees or more.

iv. Non-operative Treatment Procedures

(a). Non-displaced and minimally displaced fractures are generally treated conservatively with broad arm sling or body swath. There is some evidence that simple non-displaced proximal humeral fractures recover normal function more quickly when physical therapy is started one week after the fracture than when it is started three weeks after the fracture. Immobilization without physical therapy for more than one week is not recommended.

(b). Anterior or posterior dislocation associated with minimally displaced fractures can usually be reduced by closed means, but a general anesthetic is needed. These are usually not performed in the emergency room in order to avoid displacement of the fracture.

(c). Medication, such as analgesics and nonsteroidal anti-inflammatories, would be indicated; narcotics may be indicated acutely for fracture and should be prescribed as indicated in Medications.

(d). Immobilization may be provided with a sling, to support the elbow, or with an abduction immobilizer if a non-impacted greater tuberosity fragment is present. Immobilization is usually continued for four to six weeks; however, the time will vary according to the type of fracture and surgeon's discretion.

(e). Shoulder rehabilitation is begun with pendulum exercises 0 to 14 days after injury. Light, functional exercises may be added at two to four weeks post-injury. Subsequently, with pain control, the therapy program can be progressed with therapeutic approaches as described in Non-operative Treatment Procedures. Home exercises are essential for recovery.

(i). Time to Produce Effect: Six sessions.

(ii). Optimum Duration: Nine sessions.

(iii). Maximum Duration: 12 to 24 sessions.

(f). Use of the injured arm at work is determined by the orthopaedist. The patient may, however, return to work without use of the injured arm soon after the injury. Refer to Return to Work.

(g). Also refer to osteoporosis in this Clavicular Fracture.

(h). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

v. Surgical Indications:

(a). Greater tuberosity fractures with 5mm of displacement usually require surgical fixation. However, rehabilitation may start as early as two to three days post-operatively.

(b). Two-part fractures are repaired according to the surgeon's preference. Internal fixation may be necessary to prevent varus or valgus angulation of the humerus; however, it is unclear whether this technique is more successful than more conservative treatment particularly in patients over 70. Percutaneous techniques and closed reduction have both been used.

(c). Three and four-part fractures frequently require operative treatment. Internal fixation is commonly used. Hemiarthroplasty may be used in the elderly population or for severely comminuted fractures. Use of this technique in the younger active patients frequently leads to the need for revision surgery and/or increased wear of the glenoid cavity. For four-part fractures with a fractured greater tuberosity, reverse arthroplasties have also been described, however; they should rarely be used since the long-term success of this prosthesis is currently unknown. This procedure is described under Section G. Therapeutic Procedures, Operative Shoulder Replacement (arthroplasty).

(i). Because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively.

vi. Operative Procedures: Percutaneous or internal fixation of the fracture or arthroplasty.

vii. Post-operative Treatment

(a). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatment found in Section F.

(b). Schanz pins will require removal, frequently between Two to six weeks.

(c). One-time Extracorporeal Shock Wave Therapy (ESWT) has been purported to increase healing in non-union fractures of long bones. None have been tested in prospective controlled studies. They are all considered experimental and are not recommended at this time.

(d). Bone-Growth Stimulators. (Refer to Clavicular Fractures.)

(e). Hyperbaric oxygen therapy – there is no evidence to support long-term benefit of hyperbaric oxygen therapy for non-union upper extremity fractures. It is not recommended.

(f). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

c. Humeral Shaft Fractures:

i. Occupational Relationship: A direct blow can fracture the humeral shaft at the junction of its middle and distal thirds. Twisting injuries to the arm will cause a spiral humeral shaft fracture. High energy (velocity or crush) will cause a comminuted humeral shaft fracture.

ii. Specific Physical Exam Findings may include:

(a). deformity of the arm;

(b). bruising and swelling; and/or

(c). possible sensory and/or motor dysfunction of the radial nerve.

iii. Diagnostic Testing Procedures:

(a). plain x-rays including AP view and lateral of the entire humeral shaft.

(b). vascular studies if the radial pulse is absent.

(c). compartment pressure measurements if the surrounding muscles are swollen, tense and painful and particularly if the fracture resulted from a crush injury.

iv. Non-operative Treatment Procedures:

(a). Most isolated humeral shaft fractures can be managed non-operatively.

(b). Medication, such as analgesics and nonsteroidal anti-inflammatories, would be indicated. Narcotics may be indicated acutely for fracture and should be prescribed as indicated in Section F.6, Medications.

(c). A coaptation splint may be used.

(d). At two to three weeks after injury, a humeral fracture orthosis may be used to allow for full elbow motion.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Other therapies outlined in Therapeutic Procedures, Non-operative, may be employed in individual cases.

(g). Refer to comments related to osteoporosis in Clavicular Fracture.

(h). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

v. Surgical Indications: Indications for operative care would include:

(a). open fracture;

(b). associated forearm or elbow fracture (i.e., the floating elbow injury);

(c). burned upper extremity;

(d). associated paraplegia;

(e). multiple injuries (polytrauma);

(f). A radial nerve palsy which presented after closed reduction;

(g). pathologic fracture related to an occupational injury; and/or

(h). inability to perform basic activities of daily living while following conservative care.

(i). because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively.

vi. Operative Procedures

(a). Accepted methods of internal fixation of the fracture include:

(i). A broad plate and screws; and/or

(ii). Intramedullary rodding with or without cross-locking screws may be used but is associated with increased shoulder pain;

(b). Human Bone Morphogenetic Protein (RhBMP). Use of this material for surgical repair of shoulder fractures requires prior authorization. Refer to Operative Procedures, for further details.

vii. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Treatment may include the following:

(a). Following rigid internal fixation, therapy may be started to obtain passive and later active shoulder motion using appropriate therapeutic approaches as

indicated in Section F, Non-operative Treatment Procedures. Active elbow and wrist motion may be started immediately. Early therapeutic rehabilitation interventions are recommended to maintain range-of-motion (ROM) and progressive strengthening.

(i). Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then to two times per week.

(ii). Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

(iii). Maximum Duration: 12 weeks. Additional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains or if a nerve injury accompanies the fracture.

(b). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

(c). Bone Growth Stimulation. (Refer to Clavicular Fractures.)

d. Scapular Fractures:

i. Occupational Relationship. These are the least common of the fractures about the shoulder and include acromial, glenoid, glenoid neck and scapular body fractures. With the exception of anterior glenoid lip fractures caused by an anterior shoulder dislocation, all other scapular fractures are due to a high-energy injury.

ii. Specific Physical Findings may include:

(a). pain about the shoulder and thorax;

(b). bruising and abrasions;

(c). possibility of associated humeral or rib fractures; and/or

(d). vascular problems (pulse evaluation and Doppler examination).

iii. Diagnostic Testing Procedures:

(a). Trauma x-ray series - AP view, axillary view, and a lateral view in the plane of the scapula.

(b). Arteriography if a vascular injury is suspected.

(c). Electromyographic exam if nerve injuries are noted.

iv. Non-operative Treatment:

(a). Non-displaced acromial, coracoid, glenoid, glenoid neck and scapular body fractures may all be treated with the use of a shoulder immobilizer.

(b). Medication, such as analgesics and nonsteroidal anti-inflammatories, would be indicated. Narcotics may be indicated acutely for fracture and should be prescribed as indicated in Medications.

(c). Pendulum exercises may be started within the first week.

(d). Progress to assisted range-of-motion exercises at three to four weeks using appropriate therapeutic procedures as indicated in Section F, Non-operative Treatment Procedures.

(e). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(f). Refer to comments related to osteoporosis in Clavicular Fracture.

(g). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

v. Surgical Indications

(a). displaced acromial fractures.

(b). displaced glenoid fractures.

(c). displaced scapular body fractures in some circumstances.

(d). displaced fractures of the scapular neck and the ipsilateral clavicle.

(e). because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively.

vi. Operative Treatment

(a). displaced acromial fractures are treated with internal fixation.

(b). displaced glenoid fractures greater than 5 mm should be fixed internally. Fractures with less displacement may be treated surgically according to the surgeon's discretion. Two and three dimensional CT scans may be useful in planning the surgical approach.

(c). displaced scapular body fractures require internal fixation if the lateral or medial borders are displaced to such a degree as to interfere with scapulothoracic motion.

(d). displaced fractures of the scapular neck and the ipsilateral clavicle require internal fixation of the clavicle to reduce the scapular neck fracture.

vii. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist using the appropriate therapeutic procedures as indicated in Section F, Non-operative Treatment Procedures. Treatment may include the following:

(a). A shoulder immobilizer is utilized. Pendulum exercises initially begin at one week, and deltoid isometric exercises are started early at four to six weeks, active ROM is usually commenced.

(b). Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening.

(i). Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

(ii). Optimum Duration: 8 to 10 weeks with progression to home exercise and/or pool therapy.

(iii). Maximum Duration: 12 to 14 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

(c). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

e. Sternoclavicular Dislocation/Fracture

i. Occupational Relationship: Sudden trauma to the shoulder/anterior chest wall. Anterior dislocations of the sternoclavicular joint usually do not require active treatment; however, symptomatic posterior dislocations will require reduction.

ii. Specific Physical Findings may include:

(a). Dysphagia and shortness of breath which requires emergency reduction.

- (b). Pain at the sternoclavicular area;
- (c). Abrasions on the chest wall, clavicle and shoulder;
- (d). Deformities in the above regions; and/or
- (e). Pain with palpation and motion at the sternoclavicular joint area.

iii. Diagnostic Testing Procedures:

(a). Plain x-rays of the sternoclavicular joint are routinely done. When indicated, comparative views of the contralateral limb may be necessary.

(b). X-rays of other shoulder areas and chest may be done if clinically indicated.

(c). CT scan for classification of pathology.

(d). Vascular studies should be considered if the history and clinical examination indicate extensive injury.

iv. Non-operative Treatment Procedures:

(a). Symptomatic posterior dislocations should be reduced in the operating room under general anesthesia.

(b). Immobilize with a sling for three to four weeks. Subsequently, further rehabilitation may be utilized using procedures set forth in Non-operative Treatment Procedures.

(c). Medications, such as analgesics and nonsteroidal anti-inflammatories, would be indicated. Narcotics may be indicated acutely for fracture and should be prescribed as indicated in Medications.

(d). Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(e). Refer to comments related to osteoporosis in Clavicular fracture.

(f). Smoking may affect fracture healing. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

v. Surgical Indications:

(a). failure of closed reduction.

(b). because smokers have a higher risk of non-union and post-operative costs, it is recommended that carriers cover a smoking cessation program peri-operatively.

vi. Operative Procedures

(a). reduction with soft tissue reconstruction is preferred;

(b). internal fixation - significant complications can occur with use of pins due to migration into other tissues.

vii. Post-operative Treatment: An individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with four to six weeks of rest with a shoulder immobilizer, followed by therapeutic rehabilitation interventions.

(a). Early therapeutic rehabilitation interventions are recommended to maintain ROM with progressive strengthening.

(i). Frequency: Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

(ii). Optimum Duration: Six to eight weeks with progression to home exercise and/or pool therapy.

(iii). Maximum Duration: 12 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

(b). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

13. Impingement Syndrome

a. Description/Definition: A collection of symptoms, not a pathologic diagnosis. The symptoms result from the encroachment of the acromion, coracoacromial ligament, coracoid process, and/or the AC joint of the rotator cuff mechanism that passes beneath them as the shoulder is moved. The cuff mechanism is intimately related to the coracoacromial arch. Separated only by the thin lubricating surfaces of the bursa, compression and friction can be minimized by several factors, such as:

i. shape of the coracoacromial arch that allows passage of the subjacent rotator cuff;

ii. normal undersurface of the AC joint;

iii. normal bursa;

iv. normal capsular laxity; and

v. coordinated scapulothoracic function.

b. The impingement syndrome may be associated with AC joint arthritis and both partial and full thickness rotator cuff tears, as well as, adhesive capsulitis/frozen shoulder. Normal function of the rotator cuff mechanism and biceps tendon assist to diminish impingement syndrome.

i. History may include

(a). delayed presentation (since the syndrome is usually not an acute problem). Patients will access care if their symptoms have not resolved with rest, time and "trying to work it out";

(b). complaints of functional losses due to pain, stiffness, weakness and catching when the arm is flexed and internally rotated; and

(c). sleep complaints are common and pain is often felt down the lateral aspect of the upper arm near the deltoid insertion or over the anterior proximal humerus.

(d). occupational Relationship: Repetitive overuse of the upper extremity, often seen with constant overhead motion.

c. specific Physical Exam Findings may include: As with most shoulder diagnoses, the examiner should not rely upon one set of physical exam findings alone due to the lack of specificity and sensitivity of most tests and common overlap of diagnoses. Physical examination findings may include the following:

i. Range-of-motion is limited particularly in internal rotation and in cross-body adduction, which may reflect posterior capsular tightness. Forward flexion and elevation may also be limited.

ii. Passive motion through the 60 to 90 degrees arc of flexion may be accompanied by pain and crepitus. This is accentuated as the shoulder is moved in-and-out of internal rotation.

iii. Active elevation of the shoulder is usually more uncomfortable than passive elevation.

iv. Pain on maximum active forward flexion is frequently seen with impingement syndrome, but is not specific for diagnosis.

v. Strength testing may reveal weakness of flexion and external rotation in the scapular plane. This weakness may be the result of disuse, tendon damage, or poor scapulothoracic mechanics.

vi. Pain on resisted abduction or external rotation may also indicate that the integrity of the rotator cuff tendons may be compromised, causing alteration of shoulder mechanics.

vii. Weakness of the posterior scapular stabilizers causing alteration of shoulder mechanics can also contribute to impingement syndrome.

viii. If inspection of the shoulder reveals deltoid and rotator cuff atrophy other diagnoses should be suspected such as cervical radiculopathy, axillary nerve pathology, or massive rotator cuff tears.

(a). Impingement syndromes commonly co-exist with other shoulder abnormalities such as rotator cuff tears, AC joint arthritis, biceps tendon ruptures, calcifying tendonitis, bursitis, labral tears, and in older patients, glenohumeral instability. This combination of pathology further complicates diagnostic decisions based mainly on clinical findings. Physicians use a combination of test results with history and other findings to create a differential diagnosis.

(b). Commonly used clinical tests include the following:

- (i). Hawkins;
- (ii). Neer;
- (iii). Horizontal adduction;
- (iv). Drop arm test;
- (v). Yergason's;
- (vi). Speed test.

(c). Diagnostic Testing Procedures

(i). Plain x-rays include:

[a]. AP view is useful to evaluate for arthritis and elevation of the humeral head which are not typically present in impingement syndrome.

[b]. Lateral view in the plane of the scapula or an axillary view can help to determine aspects of instability which can give symptoms similar to impingement syndrome.

[c]. Axillary view is also useful to demonstrate glenohumeral arthritis and spurs on the anterior inferior acromion.

[d]. Outlet view determines if there is a downward curved acromion. A downward curved acromion does not necessarily establish the diagnosis of impingement syndrome and is not a sole indication for operative treatment.

(ii). Adjunctive testing, sonography or MRI, may be considered when shoulder pain is refractory to four to six weeks of non-operative conservative treatment and the diagnosis is not readily identified by a good history and clinical examination. (Refer to Follow-up Diagnostic Procedures.)

(iii). The subacromial injection has generally been considered the gold standard for differentiating ROM loss from impingement versus rotator cuff tears. Alleviation from pain may help to confirm the diagnosis. Patients with impingement should recover normal strength after the injection, while those with rotator cuff tears usually do not recover normal strength. However, manually tested elevation strength perceived as normal does not always rule out rotator cuff tear and this may contribute to incorrect diagnoses with this technique. There is good evidence that blinded subacromial blocks are not accurate.

Up to a third of blinded injections may involve the cuff, and are likely to cause pain. This may lead to an incorrect diagnosis. One study demonstrated that at least half of the positive responders did so up to 40 minutes after the injection. Therefore, a negative response should not be diagnosed until 40 minutes post injection. The inaccuracy of the injection and patient response in some cases may contribute to its inability to completely predict the amount of recovery from subacromial decompression.

(iv). If there is a concern regarding needle placement, sonography or fluoroscopy may be used.

(v). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks after injections.

(d). Non-operative Treatment Procedures

(i). An aggressive attempt should be made to define the contributing factors which are driving the syndrome, such as shoulder stiffness, humeral head depressor weakness (rotator cuff fiber failure), posterior capsular tightness and subacromial crowding, AC joint arthritis, muscle imbalance, and postural dysfunction.

(ii). Benefits may be achieved through therapeutic interventions. They should include ROM, active therapies, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM and strength of the shoulder girdle musculature. Refer to Therapeutic Procedures, Non-operative.

(iii). There is some evidence that manual therapy at a frequency of three times per week for four weeks, increases function and decreases pain.

(iv). Patients may return to work without overhead activities and lifting with involved arm. An evaluation of the jobsite may be necessary to institute ergonomic changes or accommodations. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

(v). Medications, such as nonsteroidal anti-inflammatories and analgesics, should be prescribed. Refer to Medications.

(vi). Subacromial space injection may be therapeutic. Injections under significant pressure should be avoided as the needle may be penetrating the tendon and injection into the tendon can cause tendon degeneration, tendon breakdown, or rupture. Injections should be minimized for patients under 30 years of age.

[a]. Time to Produce Effect: One Injection.

[b]. Maximum: Three injections at the same site per year when functional benefits are demonstrated with each injection. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks post injections.

(vii). Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

(e). Surgical Indications

(i). When functional deficits interfere with activities of daily living and/or job duties after three to six

months of active patient participation in non-operative therapy, surgery may restore functional anatomy and reduce the potential for repeated impingement. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan including home exercise. The provider should be especially careful to make sure the patient understands the amount of post-operative therapy required and the length of partial and full disability expected post-operatively.

(f). Operative Procedures

(i). Procedures might include partial coracoacromial ligament release, and an acromioplasty, as well as, repair of associated pathology. An acromioplasty is not always necessary as an adjunct to rotator cuff repair. There is some evidence that patients with a full-thickness rotator cuff tear and Type II acromions do not show appreciable benefit from subacromial decompression.

(ii). Coplaning of the clavicle involves the removal of spurs from its inferior surface with the purpose of increasing the space available for movement of the supraspinatus tendon. It is an acceptable procedure. Studies are conflicting regarding possible pain sequelae at the acromioclavicular joint as a consequence of the procedure. In cases with extensive rotator cuff repair, preservation of the coraco-acromial ligament is recommended to maintain joint stability.

(g). Post-operative Treatment

(i). An individualized rehabilitation program based upon communication between the surgeon and the therapist using the treatments found in Therapeutic Procedures, Non-operative. Treatment may include the following:

(ii). sling, pillow sling, or abduction splint;

(iii). gentle pendulum exercise, passive glenohumeral range-of-motion, and posterior scapular stabilizing training can be instituted;

(iv). patients can judiciously return to activities as tolerated per physician recommendations. If there is a significant tendon repair, progression will be delayed;

(v). Progressive resistive exercise from six to eight weeks with gradual returning to full activity at four to six months.

(vi). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon. Depending upon the patient's functional response and their job requirements, return to work with job modifications may be considered as early as one week post-operatively, depending on job requirements. The employer must be able to fully accommodate restrictions of overhead activities or heavy lifting. Work restrictions should be evaluated every four to six weeks during post-operative recovery and rehabilitation with appropriate written communications to both the patient and the employer. Should progress plateau, the provider should re-evaluate the patient's condition and make appropriate adjustments to the treatment plan.

14. Rotator Cuff Tear

a. Description/Definition: Partial or full-thickness tears of the rotator cuff tendons, most often the supraspinatus, can be caused by vascular, traumatic or degenerative factors or a combination. Further tear classification includes: a small tear is less than 1cm; medium tear is 1 to 3cm; large tear is 3 to 5cm; and massive tear is greater than 5cm, usually with retraction. Partial thickness cuff tears usually occur in age groups older than 30. Full-thickness tears can occur in younger age groups. Patient usually complains of pain along anterior, lateral shoulder or posterior glenohumeral joint.

b. Occupational Relationship: May be caused by sudden trauma to the shoulder such as breaking a fall using an overhead railing or an out-stretched arm; or chronic overuse with repetitive overhead motion or heavy lifting; or moderate lifting in de-conditioned workers.

c. Specific Physical Exam Findings may include

i. partial Thickness Tear

(a). There may be pain at the end of range-of-motion (ROM) when full passive ROM for abduction, elevation, external rotation and internal rotation are obtainable;

(b). Occasionally, there is a restriction of passive motion in one or more planes;

(c). Active ROM will be limited and painful for abduction and external rotation, as well as internal rotation and forward flexion;

(d). A painful arc may be present with active elevation;

(e). Pain will be positive for resisted tests (abduction, flexion, external rotation, internal rotation, abduction/internal rotation at 90 degrees, and abduction/external rotation at 45 degrees); and/or

(f). There may be positive impingement signs, refer to Impingement Syndrome.

ii. Full-Thickness Tear

(a). Passive and resisted findings are similar to those for partial thickness tears with greater weakness of abduction and external rotation;

(b). Active elevation may be severely limited with substitution of scapular rotation;

(c). Occasionally strength remains well preserved.

(d). Rotator cuff tears commonly co-exist with other shoulder abnormalities such as impingement, AC joint arthritis, bicep tendon ruptures, calcifying tendonitis, and older patients with glenohumeral instability, bursitis, and labral tears. This combination of pathology further complicates diagnostic decisions based mainly on the clinical findings. Full-thickness tears are usually readily apparent from the drop arm test or weakness with elevation. For other diagnoses, physicians should use a combination of test results with history and other findings to create a differential diagnosis. The following tests may be used:

(i). Hawkins.

(ii). Drop Arm.

(iii). Lift Off.

(iv). Subscapularis Strength Test.

(v). Empty Can Test.

(vi). External Rotation Lag Test.

(e). Neurological lesions can occur with rotator cuff tears or may be missed as isolated lesions. When

muscle atrophy and weakness are present, the physician should consider neurologic lesions in the differential diagnoses.

d. Diagnostic Testing Procedures

i. AP view is useful to evaluate for arthritis and elevation of the humeral head. Superior migration of the humeral head is indicative of an extensive, and possibly irreparable, rotator cuff tear.

ii. Lateral view in the plane of the scapula or an axillary view can help to determine aspects of instability which can give symptoms similar to impingement syndrome.

iii. The axillary view is also useful to demonstrate glenohumeral arthritis and spurs on the anterior inferior acromion.

iv. Outlet view determines if there is a downward curved acromion. A downward curved acromion does not necessarily establish the diagnosis of impingement syndrome and is not a sole indication for operative treatment.

(a). Cases with the presence of significant weakness on elevation or rotation, a palpated defect at the greater tuberosity or a traumatic history should have early MRI. Adjunctive testing such as sonography or MRI should be considered for other shoulder cases refractory to four to six weeks of non-operative conservative treatment. Sonography may be better at detecting partial thickness tears but is operator dependent. The sonogram is very specific for rotator cuff tears but is not sensitive.

(b). Rotator cuff tears, both full-thickness and partial, appear to occur commonly in asymptomatic individuals. Sonographic diagnostic criteria for rotator cuff tear may be met in approximately 39 percent of asymptomatic persons, and MRI criteria for rotator cuff tear may occur in approximately 26 percent of asymptomatic persons. There also appears to be a linear trend with age, such that more than half of asymptomatic individuals over the age of 60 may demonstrate imaging changes consistent with rotator cuff tear, while a small minority of patients younger than 40 demonstrate these changes. Correlation of radiological and clinical findings is an important part of patient management.

e. Non-operative Treatment Procedures

i. Medications, such as nonsteroidal anti-inflammatories and analgesics, would be indicated. Acute rotator cuff tear may indicate the need for limited narcotic use.

ii. Relative rest initially and procedures outlined in Non-operative Treatment Procedures. Therapeutic rehabilitation interventions may include ROM and use a home exercise program and passive modalities for pain control. Therapy should progress to strengthening and independent home exercise programs targeted to ongoing ROM and strengthening of shoulder girdle musculature.

iii. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

iv. Other therapies outlined in Therapeutic Procedures, Non-operative, may be employed in individual cases.

f. Surgical Indications

i. Goals of surgical intervention are to restore functional anatomy by re-establishing continuity of the

rotator cuff, addressing associated pathology and reducing the potential for repeated impingement.

ii. Surgery may be indicated when functional deficits interfere with activities of daily living and/or job duties after 6 to 12 weeks of active patient participation in non-operative therapy.

iii. If no increase in function for a partial tear is observed after 6 to 12 weeks, a surgical consultation is indicated. For full-thickness tears it is thought that early surgical intervention produces better surgical outcome due to healthier tissues and often less limitation of movement prior to and after surgery. Patients may need pre-operative therapy to increase ROM.

iv. Full-thickness tears in individuals less than 60 should generally be repaired. Surgery for partial thickness tears has variable results and debridement should be performed early in younger active patients. Many patients with partial tears and good ROM and strength recover well without surgery. In patients over 65 the decision to repair a full rotator cuff tear depends on the length of time since the injury, the amount of muscle or tendon that has retracted, the level of fatty infiltration and the quality of the tendon. Procedures for these patients may include biceps tendon repair and shaving of the humeral tuberosity. For patients with lack of active elevation above 90 degrees, arthroscopic biceps tenotomy and tenodesis may be effective in returning some elevation. Recurrence rate may be up to 50 percent in older patients with multiple tendon full-thickness tears. Pseudo paralysis or severe rotator cuff arthropathy are contraindications to the procedure.

v. Literature suggests that the presence of three of the following factors may decrease the likelihood of a successful repair: decreased passive ROM, superior migration of the humeral head, presence of atrophy, and/or external rotation/abduction weakness strength. Presence of these conditions is not necessarily contraindications to surgery, however, the patient should be made aware that the outcome may be less predictable.

vi. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively.

vii. Smoking may affect soft tissue healing through tissue hypoxia. Patients should be strongly encouraged to stop smoking and provided with appropriate counseling.

g. Operative Procedures:

i. Options would include arthroscopic or open debridement and/or repair. In some cases, partial coracoacromial ligament release, and/or anterior acromioplasty.

ii. An acromioplasty is not always necessary as an adjunct to rotator cuff repair. There is some evidence that patients with a full-thickness rotator cuff tear and Type II acromions do not show appreciable benefit from subacromial decompression.

iii. Coplaning of the clavicle involves the removal of spurs from its inferior surface with the purpose of increasing the space available for movement of the

supraspinatus tendon. It is an acceptable procedure. Studies are conflicting concerning the consequences of the procedure for the stability of the acromioclavicular joint.

iv. Distal clavicular resection is not recommended for patients without AC joint pain.

v. In cases with extensive rotator cuff tear, preservation of the coracoacromial ligament is recommended to prevent instability.

vi. Arthroscopic laser treatment is not recommended due to lack of evidence regarding outcomes.

h. Post-operative Treatment: Individualized rehabilitation program based upon communication between the surgeon and the therapist. Treatment may include the following:

i. Sling, pillow sling, or abduction splint. Sling protection for a period of two to eight weeks is usually recommended after rotator cuff repair;

ii. Gentle pendulum exercise, passive glenohumeral range-of-motion in flexion and external rotation to prevent adhesions and maintain mobilization;

iii. Isometrics and activity of daily living skills usually being six weeks post-operatively.

iv. Active assisted range-of-motion exercises in supine with progression to sitting;

v. Light resistive exercise may begin at 6 to 12 weeks, depending on quality of tissue and surgeon's discretion;

vi. Pool exercise initially under therapists or surgeon's direction then progressed to independent pool program;

vii. Progression to a home exercise program is essential;

viii. Gradual resistive exercise from 3 to 12 months, with gradual return to full activity at 6 to 12 months;

ix. Time frames for therapy (excluding pool therapy).

(a). Optimum: 24 to 36 sessions.

(b). Maximum: 48 sessions. If functional gains are being achieved additional visits may be authorized for the patient to achieve their functional goal.

x. Continuous passive motion is not generally recommended. It may be used if the patient has no home assistance to regularly perform the passive movements required in the first six weeks and/or access to therapy is limited.

xi. Should progress plateau, the provider should re-evaluate the patient's condition and make appropriate adjustments to the treatment plan. Refer to Therapeutic Procedures-Non-Operative for other therapies that may be employed in individual cases.

xii. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon. Work restrictions should be evaluated every four to six weeks during post-operative recovery and rehabilitation with appropriate written communications to both the patient and employer. Return to full-duty too early in the course of tendon recovery increases the likelihood of recurrent, symptomatic tears. Animal models estimate that the infraspinatus tendon regains only 30 percent of strength at six weeks, 50 percent at three months, and 80 percent at six months. Therefore, return to any significant lifting early

in the course of recovery may result in failure of the surgery and/or recurrent tears.

#### 15. Shoulder Instability/Glenohumeral Instability

a. Description/Definition: Subluxation (partial dislocation), or dislocation of the glenohumeral joint in either an anterior, interior, posterior or a combination of positions.

i. History may include:

(a). a slipping sensation in the arm;

(b). severe pain with inability to move the arm;

(c). abduction and external rotation producing a feeling that the shoulder might "come out"; or

(d). feeling of shoulder weakness.

b. Occupational Relationship: Instability may be caused by any of the following:

i. a direct traumatic blow to the shoulder;

ii. a fall on an outstretched arm;

iii. performing repetitive forceful overhead activities similar to pitching baseball;

iv. a significant traction injury to the arm.

v. In cases of subluxation symptoms may be exacerbated or provoked by work and initially alleviated with a period of rest. Symptoms may also be exacerbated by other activities that are not necessarily work related (e.g., driving a car or sports).

c. Specific Physical Exam Findings may include

i. Anterior dislocations may exhibit loss of normal shoulder contour; fullness in the axilla and pain over the shoulder with any motion. The patient may hold the extremity in a static position;

ii. Posterior dislocations usually occur with a direct fall on the shoulder or outstretched arm resulting in posteriorly directed forces to the humeral head. Seizures or electrocution may also cause posterior dislocations. Patients present with inability to externally rotate the shoulder;

iii. Neurologic examination may reveal findings consistent with axillary nerve injuries, musculocutaneous nerve injuries, generalized brachiolexopathies or other entrapment neuropathies;

iv. Abduction and external rotation positioning classically produces apprehension in those who have anterior instability. This finding may be present with other diagnoses. If apprehension is reproduced and then relieved with positive posterior pressure after a positive first maneuver, this is considered a positive relocation test. As with all shoulder diagnoses, a combination of physical findings and history should guide the provider in determining the final diagnoses. Direct posterior stress may produce pain and apprehension in those with posterior instability;

v. The contralateral joint should always be examined. Patients who have laxity in multiple positions, who have contralateral joint laxity or who have increased external rotation (90 degrees or more) with the arm at the side are not likely to be surgical candidates and can be treated conservatively.

vi. Other clinical findings (described in the Initial Diagnostic Procedures Section C).

(a). Sulcus sign;

(b). Inferior instability;

(c). Posterior instability;

(d). Apprehension, also known as crank, fulcrum or Feagin;

- (e). Relocation;
- (f). Load and shift or anterior and posterior drawer;

d. Diagnostic Testing Procedures

i. Plain x-rays to rule out bony deficit on the glenoid, including AP, axillary view, lateral in the plane of the scapula and possibly the West Point view. Axillary view to identify larger Hill-Sachs lesion of humeral head.

ii. More difficult diagnostic cases with subtle history and physical findings suggesting instability, rotator cuff or labral tear, may require a MRI or a CT arthrogram. This imaging may be useful to evaluate for labral detachment and capsular stress injury or laxity after four to eight weeks of active patient involvement in therapy.

iii. Suspected rotator cuff tear cases may require diagnostic arthroscopy.

e. Non-operative Treatment Procedures: In subacute and/or chronic instabilities, age of onset of instability is an important part of the history. Older patients are less likely to have recurrent dislocations unless they have associated large rotator cuff tears. Therefore, the rotator cuff tear protocol should be followed if there is a suspicion of this pathology. Associated axillary nerve injuries are more common in older patients. Patients less than 30 years of age, especially males actively participating in sports, tend to have a higher recurrence rate, up to 75 percent in some series. Surgery should be considered for these patients after the first dislocation. Avoid any aggressive treatment in patients with history of voluntary subluxation or dislocation. These patients may need a psychiatric evaluation. Patient may not return to work with overhead activity or lifting with involved arm until cleared by physician for heavier activities.

i. First-time dislocation

(a). Immobilization. There is no evidence that immobilization beyond splinting for comfort initially affords any additional treatment advantage thus, it is not routinely required. Literature using MRI has shown that the Bankart lesion is separated from the bone in internal rotation and apposed to the bone in external rotation. There is some evidence that immobilization for three weeks with the shoulder in adduction and approximately 10 degrees of external rotation reduces the risk of recurrent dislocation. Decisions concerning external rotation splinting versus other options will depend on surgeon and patient preferences.

(b). Consider surgical intervention for young patients active in sports, or older patients with significant rotator cuff tears. If additional pathology is present consult appropriate diagnostic categories.

(c). Medications such as analgesics and anti-inflammatories may be helpful. (Refer to medication discussions in Medications.

(d). Other therapeutic procedures may include instruction in therapeutic exercise and proper work techniques, evaluation of occupational work station and passive modalities for pain control. (Refer to Therapeutic Procedures-Non operative, for specific time parameters.)

(e). Additional treatment may include, depending on level of improvement, manual therapy techniques, work conditioning and other treatment found in section F.

(f). Patient may not return to work with overhead activity or lifting with involved arm until cleared by physician for heavier activities. Return to work with

appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

ii. Acute or chronic dislocations: with a fracture contributing to instability;

(a). Practitioner should immobilize dislocations if in an acceptable position. Consultation should be obtained as surgical repair may be necessary.

(b). Return-to-work will be directly related to the time it takes the fracture to heal.

iii. Subacute and/or chronic instability:

(a). Chronic dislocations should first be treated similarly to acute dislocation. If continuing treatment is unsuccessful, with findings of instability, operative repair should be considered.

f. Surgical Indications

i. Identify causative agent for the instability (i.e., labral detachment, bony lesion, large rotator cuff tear, subscapularis tendon rupture, or multi-directional instability). There is strong evidence that initial operative repair in young active patients results in fewer recurrent dislocations, thus, operative repair should be considered for these patients. Those with Hill Sachs lesions, bony Bankart injuries, or significant glenoid bone loss have a worse prognosis for recurrences.

ii. Fractures not amenable to immobilization may also need operative management after the first dislocation. Even with open repairs some decrease in function should be expected. Loss of external rotation is common. In some cases the loss of motion may have an adverse effect on post-operative function. The desire for surgery should carefully balance the desire to prevent recurrent dislocations and the need for ROM.

iii. Older patients with documented large rotator cuff tears should also be considered for operative repair after first time dislocations. Repair of the rotator cuff tear alone or in combination with stabilization should be considered. Refer to the rotator cuff tear section.

iv. In general, older patients without the above lesions will suffer few recurrences, and therefore, are treated conservatively. Operative repair may be considered only after recurrent dislocations when functional deficits interfere with activities of daily living and/or job duties and active patient participation in non-operative therapy has occurred. Patients with multi-directional laxity and/or laxity in the contralateral shoulder are usually not good candidates for operative repair.

g. Operative Procedures:

i. Bankart lesion repair; or

ii. Capsular tightening. There is no evidence of benefit from thermal capsulorrhaphy and it is not recommended;

iii. Bony block transfer;

h. Post-operative Treatment:

i. An individualized rehabilitation program based upon communication between the surgeon and the therapist. Depending upon the type of surgery, the patient will be immobilized for three to six weeks.

ii. As soon as it is safe to proceed without damaging the repair, begin therapeutic exercise. Pool therapy may be beneficial. Refer to Therapeutic Procedures, Non-operative for other therapies.)

iii. During this period of time, the patient could resume working when the surgeon has cleared the patient for specific activities and appropriate modifications can be made in the workplace. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon. Full ROM, lifting and pushing are prohibited usually for at least three months. Overhead work may be restricted up to six months.

iv. MMI can be expected three months after non-operative treatment and 6 to 12 months after operative treatment. Further job assessment and adjusted work restrictions may be needed prior to the patients return to full-duty.

#### 16. Superior Labrum Anterior and Posterior (Slap) Lesions

a. Description/Definition: Lesions of the superior aspect of the glenoid labrum that extend anteriorly and posteriorly in relation to the biceps tendon insertion. There are several different types of SLAP lesions described.

i. Type I is a fraying of the superior labral edge without detachment of the labrum from the glenoid rim.

ii. Type II is a detachment of the biceps anchor from the glenoid. Three distinct Type II lesions have been described as anterior only, posterior only, or combined anterior and posterior.

iii. Type III is a bucket handle tear in the superior labrum only with biceps tendon and remainder of the superior labrum having stable attachment.

iv. Type IV is a bucket handle tear as in Type III, but with extension of the tear in to the biceps tendon. Additional types of lesions have been described that include extensions of the above-described lesions or extensions of Bankart lesions.

v. History may include:

- (a). Symptoms with overhead throwing motions;
- (b). Dislocation, subluxation, or subjective sense of instability;
- (c). Poorly localized shoulder pain that is exacerbated by overhead activities;
- (d). Catching, locking, popping or snapping;
- (e). Subtle instability.

b. Occupational Relationship: Common mechanisms of injury that are thought to contribute to SLAP lesions include: compression injury such as fall on an outstretched arm with the shoulder in forward flexion and abduction or direct blow to the glenohumeral joint; traction injury such as repetitive overhead throwing, attempting to break a fall from a height, and sudden pull when losing hold of a heavy object; driver of an automobile who is rear ended; repetitive overhead motions with force such as pitching; or a fall on adducted arm with upward force directed on elbow. In some cases no mechanism of injury can be identified.

c. Specific Physical Exam Findings: The physical examination is often nonspecific secondary to other associated intra-articular abnormalities. No one test or combination of tests has been shown to have an acceptable sensitivity and specificity or positive predictive values for diagnosing SLAP lesion. Sensitivity and specificity are relatively low for individual tests and combinations. Overall physical examination tests for SLAP lesions may be used to strengthen a diagnosis of SLAP lesion, but the decision to

proceed to operative management should not be based on physical examination alone. Refer to Initial Diagnostic Procedures for specific descriptions of these signs and tests.

- i. Speed Test.
- ii. Yergason's Test.
- iii. Active Compression (O'Brien) Test.
- iv. Jobe Relocation Test.
- v. Crank Test.
- vi. Anterior Apprehension Maneuver.
- vii. Tenderness at the bicipital groove.
- viii. Anterior Slide (Kibler) Test.
- ix. Compression Rotation Test.
- x. Pain Provocation Test.
- xi. Biceps Load Test II.

d. Diagnostic Testing Procedures:

i. Radiographs are usually normal in isolated SLAP lesions. However, they can be useful in identifying other sources of abnormalities.

ii. Magnetic resonance imaging with arthrogram has the highest reported accuracy for both diagnosis and classification of SLAP lesions; however, it may be difficult to differentiate SLAP lesions, especially Type II lesions, from normal anatomic variants and from asymptomatic age related changes.

iii. Arthroscopic evaluation is the most definitive diagnostic test.

e. Non-operative Treatment Procedures: Most SLAP lesions are associated with other pathology such as rotator cuff tears, Bankart lesions, joint instability, biceps tendon tears, and supraspinatus tears. The provider should refer to the treatment protocols for these conditions and follow both the surgical and non surgical recommendations. For suspected isolated SLAP lesions, non invasive care, consider the following.

i. Medications such as analgesics and anti-inflammatory may be helpful. (Refer to medication discussions are in Medications.)

ii. Therapeutic procedures may include instruction in therapeutic exercise and proper work techniques, evaluation of occupational work station.

iii. Benefits may be achieved through therapeutic rehabilitation and rehabilitation interventions. They should include range-of-motion (ROM), active therapies, and a home exercise program. Passive as well as active therapies may be used for control of pain and swelling. Therapy should progress to strengthening and an independent home exercise program targeted to further improve ROM and strength of the shoulder girdle musculature. (Refer to Therapeutic Procedures, Non-operative.)

iv. Subacromial bursal and/or glenohumeral steroid injections may decrease inflammation and allow the therapist to progress with functional exercise and ROM.

(a). Time to Produce Effect: One injection.

(b). Maximum Duration: Three injections in one year at least four to eight weeks apart.

(c). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose levels at least daily for two weeks after injections.

v. Return to work with appropriate restrictions should be considered early in the course of treatment. Refer to Return to Work.

vi. Other therapies in Therapeutic Procedures, Non-operative may be employed in individual cases.

f. Surgical Indications: There is a significant amount of normal anatomic variation of the superior glenoid labrum and origin of the long head of the biceps tendon. Differentiation between normal variation and pathology is imperative.

i. The physician should identify other shoulder pathology if any exists and follow the appropriate surgical indications. If a SLAP lesion is suspected, an arthroscopic exam should be performed in conjunction with the primary surgical procedure and an appropriate repair performed if necessary. See Specific Diagnosis Testing, & Treatment related sections. Or;

ii. When no additional pathology is identified and there is an inadequate response to at least three months of non-operative management with active patient participation as evidenced by continued pain with functional limitations and/or instability significantly affecting activities of daily living or work duties;

iii. Prior to surgical intervention, the patient and treating physician should identify functional operative goals and the likelihood of achieving improved ability to perform activities of daily living or work activities and the patient should agree to comply with the pre- and post-operative treatment plan and home exercise requirements. The patient should understand the length of partial and full disability expected post-operatively. The patient should also understand that non-operative treatment is an acceptable option and that a potential complication of the surgery is shoulder stiffness with pain and possibly decreased function.

g. Operative Procedures: Operative treatment of SLAP lesions depends on the type of lesion present and whether any other intra-articular abnormalities are present. The following are generally accepted protocols for surgical intervention; however, due to current lack of evidence, operative treatment is not limited to these.

i. Type I: Debridement is reasonable but not required;

ii. Type II: Repair via suture anchors or biceps tenotomy are reasonable options;

iii. Type III: Debridement or excision of the bucket handle component alone or repair via suture anchors or biceps tenotomy/tenodesis are reasonable options;

iv. Type IV: Debridement and/or biceps tenotomy or tenodesis are reasonable options.

h. Post-operative Treatment: Post-operative rehabilitation programs should be individualized and dependent upon whether any other intra-articular abnormalities exist and were operatively treated. There is a paucity of information on rehabilitation of isolated SLAP lesions. Common post-operative care involves wearing a sling, without active shoulder motion for 4 to 6 weeks. Elbow, wrist, and hand range-of-motion (ROM) exercises may be used at this time. The sling is removed at 4 to 6 weeks and active ROM is usually begun with restrictions directed by the surgeon. It is reasonable to restrict external rotation and abduction up to six months post-operative. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2325. Therapeutic Procedures - Non- Operative**

A. Treating providers, as well as employers and insurers are highly encouraged to reference the General Guideline Principles. Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these important issues in the care of the injured worker.

B. First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to "Return-to-Work" in this section for detailed information.

C. Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

D. Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

E. Lastly, formal psychological or psychosocial evaluation should be performed on patients not making expected progress within 6 to 12 weeks following injury and whose subjective symptoms do not correlate with objective signs and tests.

F. In cases where a patient is unable to attend an outpatient center, skilled home therapy may be necessary. Skilled home therapy may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone. Skilled home therapy is usually of short duration and continues until the patient is able to tolerate coming to an outpatient center.

1. Acupuncture is an accepted and widely used procedure for the relief of pain and inflammation, and there is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine literature suggests that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return to functional activity. Acupuncture should be performed by licensed practitioners.

a. Acupuncture is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

i. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

b. Acupuncture with Electrical Stimulation: is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

c. Total Time Frames for Acupuncture and Acupuncture with Electrical Stimulation: Time frames are not meant to be applied to each of the above sections separately. The time frames are to be applied to all acupuncture treatments regardless of the type or combination of therapies being provided.

- i. Time to Produce Effect: three to ix treatments.
- ii. Frequency: one to three times per week.
- iii. Optimum Duration: one to two months.
- iv. Maximum Duration: 14 treatments.

(a). Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program. Treatment beyond 14 treatments must be documented with respect to need and ability to facilitate positive symptomatic or functional gains. Such care should be re-evaluated and documented with each series of treatments.

d. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and Cold Therapy) for a description of these adjunctive acupuncture modalities and time frames.

2. Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorily, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

a. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for

biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

b. Indications for biofeedback include individuals who are suffering from musculoskeletal injury in which muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized along with other treatment modalities.

- i. Time to Produce Effect: three to four sessions.
- ii. Frequency: One to two times per week.
- iii. Optimum Duration: Five to six sessions.
- iv. Maximum Duration: 10 to 12 sessions.

Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic or functional gains.

3. Extracorporeal Shock Wave Therapy (ESWT) is used to increase function and decrease pain in patients with specified types of calcifying tendonitis who have failed conservative therapy. It is not a first line therapy. ESWT uses acoustic impulses with duration in microseconds focused on the target tissue. The mechanism of action is not known, but is not likely to be simply the mechanical disintegration of the calcium deposit. High-energy application of ESWT may be painful, and rare complications such as osteonecrosis of the humeral head have been reported. Dosage is established according to patient tolerance. Higher dosages are generally associated with better functional results. There is good evidence that ESWT may improve pain and function in radiographically or sonographically defined Type I or Type II calcium deposits when conservative treatment has failed to result in adequate functional improvement, but optimal dosing has not been defined. In the absence of a documented calcium deposit, there is no evidence that ESWT is effective and its use in this setting is not recommended. Neither anesthesia nor conscious sedation is required nor is it recommended for this procedure. There is no evidence that results with fluoroscopic guidance or with computer-assisted navigation are superior to results obtained by palpation. These are not recommended.

a. Indications - patients with calcifying tendonitis who have not achieved functional goals after two to three months of active therapy. The calcium deposits must be Type I, homogenous calcification with well-defined borders or Type II, heterogeneous with sharp border or homogenous with no defined border.

- i. Time to Produce Effect: Three days.
- ii. Frequency: Every four to seven days.
- iii. Optimum Duration: Two sessions. Progress can be documented by functional reports and/or x-ray or sonographic decrease in calcium.
- iv. Maximum Duration: Four sessions.

#### 4. Injections-Therapeutic

a. Description - Therapeutic injection procedures are generally accepted, well-established procedures that may play a significant role in the treatment of patients with upper extremity pain or pathology. Therapeutic injections involve the delivery of anesthetic and/or anti-inflammatory

medications to the painful structure. Therapeutic injections have many potential benefits. Ideally, a therapeutic injection will: reduce inflammation in a specific target area; relieve secondary muscle spasm; allow a break from pain; and support therapy directed to functional recovery. Diagnostic and therapeutic injections should be used early and selectively to establish a diagnosis and support rehabilitation. If injections are overused or used outside the context of a monitored rehabilitation program, they may be of significantly less value.

b. Indications - Diagnostic injections are procedures which may be used to identify pain generators or pathology. For additional specific clinical indications, see Specific Diagnosis, Testing and Treatment Procedures.

c. Contraindications - General contraindications include local or systemic infection, bleeding disorders, allergy to medications used and patient refusal. Specific contraindications may apply to individual injections.

i. Shoulder Joint Injections: are generally accepted, well-established procedures that can be performed as analgesic or anti-inflammatory procedures. Common shoulder joint injections include anterior and posterior glenohumeral and acromioclavicular.

(a). Time to Produce Effect: Immediate with local anesthesia, or within 3 days if no anesthesia.

(b). Optimum Duration: Usually One or two injections are adequate.

(c). Maximum Duration: Not more than three to four times annually.

(d). Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks post injections.

ii. Subacromial Injections: There is good evidence that blinded subacromial blocks are not accurate. Up to a third of blinded injections may involve the cuff and are likely to cause pain. This may lead to an incorrect diagnosis when the injection is being used diagnostically. (Refer to Diagnostic injections) If there is a concern regarding needle placement, sonography or fluoroscopy may be used.

iii. Soft Tissue Injections: include bursa and tendon insertions. Injections under significant pressure should be avoided as the needle may be penetrating the tendon. Injection into the tendon can cause tendon degeneration, tendon breakdown, or rupture. Injections should be minimized for patients under 30 years of age. Steroid injections should be used cautiously in diabetic patients. Diabetic patients should be reminded to check their blood glucose level at least daily for two weeks post injections. The risk of tendon rupture should be discussed with the patient and the need for restricted duty emphasized.

(a). Frequency: Usually one or two injections are adequate.

(b). Time to Produce Effect: Immediate with local anesthesia, or within three days if no anesthesia.

(c). Optimum/Maximum Duration: Three steroid injections at the same site per year.

iv. Trigger Point Injections: although generally accepted, are not routinely used in the shoulder. However, it is not unusual to find shoulder girdle myofascial trigger points associated with shoulder pathology which may require injections.

(a). Description - Trigger point treatment can consist of dry needling or injection of local anesthetic with or without corticosteroid into highly localized, extremely sensitive bands of skeletal muscle fibers that produce local and referred pain when activated. Medication is injected in a four-quadrant manner in the area of maximum tenderness. Injection efficacy can be enhanced if injections are immediately followed by myofascial therapeutic interventions, such as vapo-coolant spray and stretch, ischemic pressure massage (myotherapy), specific soft tissue mobilization and physical modalities. There is conflicting evidence regarding the benefit of trigger point injections. A truly blinded study comparing dry needle treatment of trigger points is not feasible. There is no evidence that injection of medications improves the results of trigger-point injections. Needling alone may account for some of the therapeutic response.

(i). There is no indication for conscious sedation for patients receiving trigger point injections. The patient must be alert to help identify the site of the injection.

(b). Indications - Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas. They are to be used as an adjunctive treatment in combination with other treatment modalities such as functional restoration programs. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. Patients should continue with a therapeutic exercise program as tolerated throughout the time period they are undergoing intensive myofascial interventions. Myofascial pain is often associated with other underlying structural problems and any abnormalities need to be ruled out prior to injection.

(i). Trigger point injections are indicated in those patients where well circumscribed trigger points have been consistently observed, demonstrating a local twitch response, characteristic radiation of pain pattern and local autonomic reaction, such as persistent hyperemia following palpation. Generally, these injections are not necessary unless consistently observed trigger points are not responding to specific, noninvasive, myofascial interventions within approximately a 6-week time frame.

(ii). Complications - Potential but rare complications of trigger point injections include infection, pneumothorax, anaphylaxis, neurapraxia, and neuropathy. If corticosteroids are injected in addition to local anesthetic, there is a risk of local developing myopathy. Severe pain on injection suggests the possibility of an intraneural injection, and the needle should be immediately repositioned.

[a]. Time to Produce Effect: Local anesthetic 30 minutes; no anesthesia 24 to 48 hours.

[b]. Frequency: Weekly, suggest no more than four injection sites per session per week to avoid significant post-injection soreness.

[c]. Optimum Duration: Four Weeks.

[d]. Maximum Duration: Eight weeks.

Occasional patients may require two to four repetitions of trigger point injection series over a one to two year period.

v. Prolotherapy: (also known as Sclerotherapy/Regenerative Injection Therapy) consists of peri- or intra-ligamentous injections of hypertonic dextrose with or without phenol with the goal of inducing an inflammatory response that will recruit cytokine growth

factors involved in the proliferation of connective tissue. Advocates of prolotherapy propose that these injections will alleviate complaints related to joint laxity by promoting the growth of connective tissue and stabilizing the involved joint.

(a). Laboratory studies may lend some biological plausibility to claims of connective tissue growth, but high quality published clinical studies are lacking. The dependence of the therapeutic effect on the inflammatory response is poorly defined, raising concerns about the use of conventional anti-inflammatory drugs when proliferant injections are given. The evidence in support of prolotherapy is insufficient and therefore, its use is not recommended in upper extremity injuries.

vi. Viscosupplementation/Intracapsular Acid Salts: involves the injection of hyaluronic acid and its derivatives into the glenohumeral joint space. Hyaluronic acid is secreted into the joint space by the healthy synovium and has functions of lubrication and cartilage protection. Its use in the shoulder is not supported by scientific evidence at this time.

5. Jobsite Alteration. Early evaluation and training of body mechanics are essential for every injured worker. Risk factors to be addressed include repetitive overhead work, lifting and/or tool use. In some cases, this requires a jobsite evaluation. Some evidence supports alteration of the work site in the early treatment of shoulder injuries. There is no single factor or combination of factors that is proven to prevent or ameliorate shoulder pain, but a combination of ergonomic and psychosocial factors are generally considered to be important. Physical factors that may be considered include use of force, repetitive overhead work, and awkward overhead positions requiring use of force, upper extremity vibration, and contact pressure on the nerve. Psychosocial factors to be considered include pacing, degree of control over job duties, perception of job stress, and supervisory support. The job analysis and modification should include input from the employee, employer, and ergonomist or other professional familiar with work place evaluation. The employee must be observed performing all job functions in order for the jobsite analysis to be valid. Periodic follow-up is recommended to evaluate effectiveness of the intervention and need for additional ergonomic changes.

a. Ergonomic Changes may be made to modify the hazards identified. In addition, workers should be counseled to vary tasks throughout the day whenever possible. OSHA suggests that workers' who perform overhead repetitive tasks with or without force, take 15 to 30 second breaks every 10 to 20 minutes, or 5-minute breaks every hour. Mini-breaks should include stretching exercises.

b. Interventions should consider engineering controls (e.g., mechanizing the task, changing the tool used, or adjusting the jobsite), or administrative controls (e.g., adjusting the time an individual performs the task).

6. Medications for the treatment of upper extremity injuries is appropriate to control acute pain and inflammation. Use of medications will vary widely due to the spectrum of injuries from simple strains to complicated fractures. All drugs should be used according to patient needs. A thorough medication history, including use of alternative and over the counter medications, should be performed at the time of the initial visit and updated

periodically. Treatment for pain control is initially accomplished with acetaminophen and/or NSAIDs. The patient should be educated regarding the interaction with prescription and over-the-counter medications as well as the contents of over-the-counter herbal products.

a. Nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen are useful in the treatment of injuries associated with degenerative joint disease and/or inflammation. These same medications can be used for pain control.

b. Topical agents may be beneficial for pain management in some patients with upper extremity injuries. This includes topical capsaicin, nonsteroidal, as well as, topical iontophoretics/phonophoretics, such as steroid creams and lidocaine.

c. The following are listed in alphabetical order.

i. Acetaminophen is an effective analgesic with antipyretic but not anti-inflammatory activity. Acetaminophen is generally well tolerated, causes little or no gastrointestinal irritation and is not associated with ulcer formation. Acetaminophen has been associated with liver toxicity in overdose situations or in chronic alcohol use. Patients may not realize that many over-the-counter preparations may contain acetaminophen. The total daily dose of acetaminophen is recommended not to exceed 2250 mg per 24 hour period, from all sources, including narcotic-acetaminophen combination preparations.

(a). Optimum Duration: 7 to 10 days.

(b). Maximum Duration: Chronic use as indicated on a case-by-case basis. Use of this substance long-term for three days per week or greater may be associated with rebound pain upon cessation.

ii. Minor Tranquilizer/Muscle Relaxants are appropriate for muscle spasm, mild pain and sleep disorders. When prescribing these agents, physicians must seriously consider side effects of drowsiness or dizziness and the fact that benzodiazepines may be habit-forming.

(a). Optimum Duration: Up to one week.

(b). Maximum Duration: Four weeks.

iii. Narcotics should be primarily reserved for the treatment of severe upper extremity pain. There are circumstances where prolonged use of narcotics is justified based upon specific diagnosis and in pre- and post-operative patients. In these and other cases, it should be documented and justified. In mild-to-moderate cases of upper extremity pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

(a). Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a pain scale and assessment of function to rate effectiveness of the narcotic prescribed. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.

(i). Optimum Duration: Up to 10 days.

(ii). Maximum Duration: Two weeks for most non-operative cases. Use beyond two weeks is acceptable in appropriate cases. Refer to Chronic Pain Guidelines which provides a detailed discussion regarding medication use in chronic pain management.

iv. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) are useful for pain and inflammation. In mild cases, they may be the only drugs required for analgesia. There are several classes of NSAIDs, and the response of the individual injured worker to a specific medication is unpredictable. For this reason, a range of NSAIDs may be tried in each case with the most effective preparation being continued. Patients should be closely monitored for adverse reactions. The US Food and Drug Administration advises that many NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. Naproxen sodium does not appear to be associated with increased risk of vascular events. Administration of proton pump inhibitors, Histamine 2 Blockers, or prostaglandin analog misoprostol along with these NSAIDs may reduce the risk of duodenal and gastric ulceration but do not impact possible cardiovascular complications. Due to the cross-reactivity between aspirin and NSAIDs, NSAIDs should not be used in aspirin-sensitive patients, and should be used with caution in all asthma patients. NSAIDs are associated with abnormal renal function, including renal failure, as well as, abnormal liver function. Certain NSAIDs may have interactions with various other medications. Individuals may have adverse events not listed above. Intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication. Complete Blood Count (CBC) and liver and renal function should be monitored at least every six months in patients on chronic NSAIDs and initially when indicated.

(a). Non-selective Nonsteroidal Anti-Inflammatory Drugs:

(i). Includes NSAIDs, and acetylsalicylic acid (aspirin). Serious GI toxicity, such as bleeding, perforation, and ulceration can occur at any time, with or without warning symptoms in patients treated with traditional NSAIDs. Physicians should inform patients about the signs and/or symptoms of serious gastrointestinal toxicity and what steps to take if they occur. Anaphylactoid reactions may occur in patients taking NSAIDs. NSAIDs may interfere with platelet function. Fluid retention and edema have been observed in some patients taking NSAIDs.

[a]. Optimal Duration: One week.

[b]. Maximum Duration: One year. Use of these substances long-term (Three days per week or greater) is associated with rebound pain upon cessation.

(b). Selective Cyclo-oxygenase-2 (COX-2) Inhibitors:

(i). COX-2 inhibitors are more recent NSAIDs and differ in adverse side effect profiles from the traditional NSAIDs. The major advantages of selective COX-2 inhibitors over traditional NSAIDs are that they have less gastrointestinal toxicity and no platelet effects. COX-2 inhibitors can worsen renal function in patients with renal insufficiency, thus renal function may need monitoring.

(ii). COX-2 inhibitors should not be first-line for low risk patients who will be using an NSAID short term but are indicated in select patients for whom traditional NSAIDs are not tolerated. Serious upper GI adverse events can occur even in asymptomatic patients. Patients at high risk for GI bleed include those who use alcohol, smoke, are older than 65, take corticosteroids or anti-coagulants, or

have a longer duration of therapy. Celecoxib is contraindicated in sulfonamide allergic patients.

[a]. Optimal Duration: 7 to 10 days.

[b]. Maximum Duration: Chronic use is appropriate in individual cases. Use of these substances long-term (three days per week or greater) is associated with rebound pain upon cessation.

v. Oral Steroids: have limited use but are accepted in cases requiring potent anti-inflammatory drug effect in carefully selected patients. A one-week regime of steroids may be considered in the treatment of patients who have arthritic flare-ups with significant inflammation of the joint. The physician must be fully aware of potential contraindications for the use of all steroids such as avascular necrosis, hypertension, diabetes, glaucoma, peptic ulcer disease, etc., which should be discussed with the patient.

(a). Optimal Duration: Three to seven days.

(b). Maximum Duration: Seven days.

vi. Psychotropic/Anti-anxiety/Hypnotic Agents: may be useful for treatment of mild and chronic pain, dysesthesia, sleep disorders, and depression. Antidepressant medications, such as tricyclics and Selective Serotonin Reuptake inhibitors (SSRIs) and Selective serotonin norepinephrine reuptake inhibitors (SSNRIs), are useful for affective disorder and chronic pain management. Tricyclic antidepressant agents, in low dose, are useful for chronic pain but have more frequent side effects.

(a). Anti-anxiety medications are best used for short-term treatment (i.e., less than six months). Accompanying sleep disorders are best treated with sedating antidepressants prior to bedtime. Frequently, combinations of the above agents are useful. As a general rule, physicians should access the patient's prior history of substance abuse or depression prior to prescribing any of these agents.

(b). Due to the habit-forming potential of the benzodiazepines and other drugs found in this class, they are not routinely recommended. Refer to the Chronic Pain Guidelines which give a detailed discussion regarding medication use in chronic pain management.

(i). Optimum Duration: One to six months.

(ii). Maximum Duration: 6 to 12 months, with monitoring.

vii.. Tramadol is useful in relief of upper extremity pain and has been shown to provide pain relief equivalent to that of commonly prescribed NSAIDs. Tramadol is an atypical opioid with norepinephrine and serotonin reuptake inhibition. It is not considered a controlled substance in the U.S. Although tramadol may cause impaired alertness it is generally well tolerated, does not cause gastrointestinal ulceration, or exacerbate hypertension or congestive heart failure. Tramadol should be used cautiously in patients who have a history of seizures or who are taking medication that may lower the seizure threshold, such as MAO inhibitors, SSRIs, and tricyclic antidepressants. This medication has physically addictive properties and withdrawal may follow abrupt discontinuation and is not recommended for patients with prior opioid addiction.

(a). Optimum Duration: Three to seven days.

(b). Maximum Duration: Two weeks. Use beyond two weeks is acceptable in appropriate cases.

viii. Topical Drug Delivery. Creams and patches may be an alternative treatment of localized musculoskeletal

disorders. It is necessary that all topical agents be used with strict instructions for application as well as maximum number of applications per day to obtain the desired benefit and avoid potential toxicity. As with all medications, patient selection must be rigorous to select those patients with the highest probability of compliance.

(a). Topical Salicylates and Nonsalicylates have been shown to be effective in relieving pain in acute and chronic musculoskeletal conditions. Topical salicylate and nonsalicylates achieve tissue levels that are potentially therapeutic, at least with regard to COX inhibition. Other than local skin reactions, the side effects of therapy are minimal, although not nonexistent, and the usual contraindications to use of these compounds needs to be considered. Local skin reactions are rare and systemic effects were even less common. Their use in patients receiving warfarin therapy may result in alterations in bleeding time. Overall, the low level of systemic absorption can be advantageous; allowing the topical use of these medications when systemic administration is relatively contraindicated such as is the case in patients with hypertension, cardiac failure, or renal insufficiency.

(b). There is no evidence that topical agents are more effective than oral medications. Therefore, they should not generally be used unless the patient has an intolerance to anti-inflammatories.

(i). Optimum Duration: One week.

(ii). Maximum Duration: Two weeks per episode.

(c). Capsaicin is another medication option for topical drug use in upper extremity injury. Capsaicin offers a safe and effective alternative to systemic NSAID therapy. Although it is quite safe, effective use of capsaicin is limited by the local stinging or burning sensation that typically dissipates with regular use, usually after the first 7 to 10 days of treatment. Patients should be advised to apply the cream on the affected area with a plastic glove or cotton applicator and to avoid inadvertent contact with eyes and mucous membranes.

(i). Optimum Duration: One week.

(ii). Maximum Duration: Two weeks per episode.

(d). Other Agents. Other topical agents, including prescription drugs (i.e., lidocaine), prescription compound agents, and prescribed over-the-counter medications (i.e., blue ice), may be useful for pain and inflammation. These drugs should be used according to patient needs.

(i). Optimum Duration: Varies with drug or compound.

(ii). Maximum Duration: Varies with drug or compound.

(e). Iontophoretic Agents: Refer to Iontophoresis under Passive Therapy of this section.

## 7. Occupational Rehabilitation Programs

a. Non-Interdisciplinary. These generally accepted programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return to work.

The service may include the time-limited use of passive modalities with progression to achieve treatment and/or simulated/real work. These programs are frequently necessary for patients who must return to physically demanding job duties or whose injury requires prolonged rehabilitation and therapy spanning several months.

i. Work Conditioning. These programs are usually initiated once reconditioning has been completed, but may be offered at any time throughout the recovery phase. It should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

(a). Length of visit: One to two hours per day.

(b). Frequency: Two to five visits per week.

(c). Optimum Duration: Two to five weeks.

(d). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

ii. Work Simulation. Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

(a). Length of visit: Two to six hours per day.

(b). Frequency: Two to five visits per week.

(c). Optimum Duration: Two to four weeks.

(d). Maximum Duration: Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

b. Interdisciplinary. These generally accepted programs are characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of an injured workers program with the goal for patients to gain full or optimal function and return to work. There should be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals. These programs are for patients with greater levels of perceived disability, dysfunction, de-conditioning and psychological involvement. For patients with chronic pain, refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

i. Work Hardening. Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, psychological, behavioral, physical, functional, and vocational components of employability and return-to-work.

ii. This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who

is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation, occupational therapist; physical therapist; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, or vocational specialist or Certified Biofeedback Therapist.

- (a). Length of visit: Up to eight hours/day.
- (b). Frequency: Two to five visits per week.
- (c). Optimum Duration: Two to four weeks.
- (d). Maximum Duration. Six weeks.

Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

#### 8. Orthotics and Prosthetics

a. Fabrication/Modification of Orthotics facilitate better motion response, stabilize a joint with insufficient muscle or proprioceptive/reflex competencies, to protect subacute conditions as needed during movement, and correct biomechanical problems. For specific types of orthotics/prosthetics, refer to Specific Diagnosis, Testing and Treatment Procedures.

- i. Time to Produce Effect: One to three sessions (includes wearing schedule evaluation).
- ii. Frequency: One to two times per week.
- iii. Optimum/Maximum Duration: Four sessions of evaluation, casting, fitting, and re-evaluation.

b. Orthotic/Prosthetic Training is the skilled instruction (preferably by qualified providers) in the proper use of orthotic devices and/or prosthetic limbs including stump preparation, donning and doffing limbs, instruction in wearing schedule and orthotic/prosthetic maintenance training. Training can include activities of daily living and self-care techniques.

- i. Time to Produce Effect: Two to six sessions.
- ii. Frequency: Three times per week.
- iii. Optimum/Maximum Duration: Two to four months.

c. Splints or adaptive equipment design, fabrication and/or modification indications include the need to control neurological and orthopedic injuries for reduced stress during functional activities and modify tasks through instruction in the use of a device or physical modification of a device, which reduces stress on the injury. Equipment should improve safety and reduce risk of re-injury. This includes high and low technology assistive options such as workplace modifications, computer interface or seating, and self-care aids.

- i. Time to Produce Effect: Immediate.
- ii. Frequency: One to three sessions or as indicated to establish independent use.
- iii. Optimum/Maximum Duration: One to three sessions.

9. Patient Education. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should be encouraged to take an active role in the establishment of functional outcome goals. They should be educated on their specific injury, assessment findings, and plan of treatment. Instruction on proper body mechanics and posture, positions

to avoid, self-care for exacerbation of symptoms, and home exercise should also be addressed.

a. Time to Produce Effect: Varies with individual patient.

b. Frequency: Should occur at each visit.

10. Personality/Psychosocial/Psychiatric/Psychological Intervention. Psychosocial treatment is generally accepted widely used and well-established intervention. This group of therapeutic and diagnostic modalities includes, but is not limited to, individual counseling, group therapy, stress management, psychosocial crises intervention, hypnosis and meditation. Any evaluation or diagnostic workup should clarify and distinguish between pre-existing versus aggravated versus purely causative psychological conditions. Psychosocial intervention is recommended as an important component in the total management program that should be implemented as soon as the problem is identified. This can be used alone or in conjunction with other treatment modalities. Providers treating patients with chronic pain should refer to the OWCA's Chronic Pain Disorder Medical Treatment Guidelines.

a. Time to Produce Effect: Two to four weeks.

b. Frequency: One to three times weekly for the first four weeks (excluding hospitalization, if required), decreasing to one to two times per week for the second month. Thereafter, two to four times monthly.

c. Optimum Duration: Six weeks to three months.

d. Maximum Duration. 3 to 12 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervised treatment may be required, and if further counseling beyond 3 months is indicated, extensive documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating provider every 4 to 6 weeks during treatment.

11. Restriction of Activities varies according to the specific diagnosis and the severity of the condition. Job modification/modified duty are frequently required to avoid exacerbation of the injured shoulder. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with upper extremity injuries.

12. Return-to-work. Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months. It is imperative that the patient be educated regarding the benefits of return-to-work, work restrictions, and follow-up if problems arise. When attempting to return a patient to work after a specific injury, clear objective restrictions of activity level should be made. An accurate job description with detailed physical duty restrictions is often necessary to assist the physician in making return-to-work recommendations. This may require a jobsite evaluation.

a. Employers should be prepared to offer transitional work. This may consist of temporary work in a less demanding position, return to the regular job with restrictions, or gradual return to the regular job. Company policies which encourage return-to-work with positive

communication are most likely to have decreased worker disability.

b. Return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Due to the large spectrum of injuries of varying severity and varying physical demands in the work place, it is not possible to make specific return-to-work guidelines for each injury. Therefore, the OWCA recommends the following:

i. Establishment of a Return-to-Work Status. Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan, and addressed at every visit. A description of daily activity limitations is part of any treatment plan and should be the basis for restriction of work activities. In most non-surgical cases the patient should be able to return to work in some capacity or in an alternate position consistent with medical treatment within several days unless there are extenuating circumstances. Injuries requiring more than two weeks off work should be thoroughly documented. Refer to Specific Diagnoses in Post-operative Return to Work Subsections.

ii. Establishment of Activity Level Restrictions. Communication is essential between the patient, employer and provider to determine appropriate restrictions and return-to-work dates. It is the responsibility of the physician to provide clear, concise restrictions, and it is the employer's responsibility to determine if temporary duties can be provided within the restrictions. For shoulder injuries, the following should be addressed when describing the patient's activity level:

(a). Activities such as overhead motion, lifting, abduction;

(b). Static shoulder positions with regard to duration and frequency;

(c). Use of adaptive devices or equipment for proper ergonomics and to enhance capacities;

(d). Maximum lifting limits with reference to the frequency of the lifting and/or the object height level; and

(e). Maximum limits for pushing, pulling, with limits on bending and twisting at the waist as necessary.

iii. Compliance with Activity Restrictions. In some cases, compliance with restriction of activity levels may require a complete jobsite evaluation, a functional capacity evaluation (FCE), or other special testing. Refer to "Special Tests" of this section.

### 13. Therapy-Active

a. The following active therapies are widely used and accepted methods of care for a variety of work-related injuries. They are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). At times, the provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

b. Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow-up visits to

reinforce and monitor progress and proper technique are recommended. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Frequency times and duration of treatment apply only to diagnoses not previously covered in Section E.

i. Activities of Daily Living (ADL) are well-established interventions which involve instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily activities such as self-care, work re-integration training, homemaking, and driving.

(a). Time to Produce Effect: Four to five treatments.

(b). Frequency: Three to five times per week.

(c). Optimum Duration: Four to six weeks.

(d). Maximum Duration: Six weeks.

ii. Aquatic Therapy is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote ROM, flexibility, strengthening, core stabilization, endurance, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely to have a successful trial of therapeutic exercise. Literature has shown that the muscle recruitment for aquatic therapy versus similar non-aquatic motions is significantly less. Because there is always a risk of recurrent or additional damage to the muscle tendon unit after a surgical repair, aquatic therapy may be preferred by surgeons to gain early return of ROM. In some cases the patient will be able to do the exercises unsupervised after the initial supervised session. Parks and recreation contacts may be used to locate less expensive facilities for patients. Indications include:

(a). Postoperative therapy as ordered by the surgeon;

(b). Intolerance for active land-based or full-weight bearing therapeutic procedures;

(c). Symptoms that are exacerbated in a dry environment; and/or

(d). Willingness to follow through with the therapy on a regular basis.

iii. The pool should be large enough to allow full extremity ROM and fully erect posture. Aquatic vests, belts, snorkels, and other devices may be used to provide stability, balance, buoyancy, and resistance.

(a). Time to Produce Effect: Four to five treatments.

(b). Frequency: Three to five times per week.

(c). Optimum Duration: Four to six weeks.

(d). Maximum Duration: Eight weeks.

iv. A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a self-directed dry environment exercise program.

v. Functional Activities are well-established interventions which involve the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, balance, and sensory motor integration.

(a). Time to Produce Effect: Four to five treatments.

(b). Frequency: Three to five times per week.

(c). Optimum Duration: Four to six weeks.

(d). Maximum Duration: Six weeks.

vi. Functional Electrical Stimulation is an accepted treatment in which the application of electrical current to elicit involuntary or assisted contractions of atrophied and/or impaired muscles. Indications include muscle atrophy, weakness, and sluggish muscle contraction secondary to pain, injury, neuromuscular dysfunction or peripheral nerve lesion. Indications also may include an individual who is precluded from active therapy.

(a). Time to Produce Effect: Two to six treatments.

(b). Frequency: Three times per week.

(c). Optimum Duration: Eight weeks.

(d). Maximum Duration: Eight weeks. If functional gains are documented by a therapist, a home unit may be provided.

vii. Neuromuscular Re-education is a generally accepted treatment. It is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength; movement patterns; neuromuscular response; proprioception; kinesthetic sense; coordination; education of movement, balance and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and to improve neuromotor response with independent control.

(a). Time to Produce Effect: Two to six treatments.

(b). Frequency: Three times per week.

(c). Optimum Duration: Four to eight weeks.

(d). Maximum Duration: Eight weeks.

viii. Therapeutic Exercise is a generally well-accepted treatment. Therapeutic exercise, with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. The exact type of program and length of therapy should be determined by the treating physician with the physical or occupational therapist. Refer to Specific Diagnosis, Testing and Treatment Procedures regarding specific diagnoses for details. In most cases, the therapist instructs the patient in a supervised clinic and home program to increase motion and subsequently increase strength. Usually, isometrics are performed initially, progressing to isotonic exercises as tolerated.

(a). Time to Produce Effect: Two to six treatments.

(b). Frequency: Two to three times per week.

(c). Optimum Duration: 16 to 24 sessions.

(d). Maximum Duration. 36 sessions. Additional visits may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co-morbidities. Functional gains including increased ROM must be demonstrated to justify continuing treatment.

14. Therapy-Passive. Most of the following passive therapies and modalities are generally accepted methods of care for a variety of work-related injuries. Passive therapy

includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used adjunctively with active therapies to help control swelling, pain, and inflammation during the rehabilitation process. They may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

a. On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care, and comorbidities may also extend durations of care. Specific goals with objectively measured functional improvement during treatment must be cited to justify extended durations of care. It is recommended that, if no functional gain is observed after the number of treatments under "time to produce effect" have been completed, alternative treatment interventions, further diagnostic studies, or further consultations should be pursued.

b. The following passive therapies and modalities are listed in alphabetical order.

i. Continuous Passive Movement (CPM): Refer to Rotator Cuff Tear.

ii. Electrical Stimulation (Unattended is an accepted treatment. Unattended electrical stimulation once applied, requires minimal on-site supervision by the physician or non-physician provider. Indications include pain, inflammation, muscle spasm, atrophy, decreased circulation, and the need for osteogenic stimulation.

(a). Time to Produce Effect: Two to four treatments.

(b). Frequency. Varies. Depending upon indication, between two to three times per day to one time a week. Provide home unit if frequent use.

(c). Optimum Duration: One to three months.

(d). Maximum Duration: Three months.

iii. Hyperbaric Oxygen Therapy. There is no evidence to support long-term benefit of hyperbaric oxygen therapy for non-union upper extremity fractures. It is not recommended.

iv. Immobilization: Time is dependent upon type of injury.

(a). Time to Produce Effect: One day.

(b). Frequency: Once.

(c). Optimum Duration: One week.

(d). Maximum Duration: 12 weeks.

(e). The arm may be immobilized in a sling for 1 to 12 weeks post-injury, depending upon the age of the patient and diagnosis. The patient is instructed in isometric exercises while in the sling for the internal and external rotators and the deltoid.

v. Iontophoresis is an accepted treatment which consists of the transfer of medication, including, but not limited to, steroidal anti-inflammatory and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, salicylate), ischemia (magnesium, mecholy, iodine), muscle spasm (magnesium,

calcium), calcifying deposits (acetate), scars, and keloids (chlorine, iodine, acetate).

(a). Time to Produce Effect: One to four treatments.

(b). Frequency: 3 times per week with at least 48 hours between treatments.

(c). Optimum Duration: 8 to 10 treatments.

(d). Maximum Duration: 10 treatments.

vi. Manipulation is a generally accepted, well-established and widely used therapeutic intervention for shoulder injuries. Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

(a). High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment. This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), properly trained occupational therapists (O.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as direct- a forceful engagement of a restrictive/pathologic barrier, indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier, the patient actively assists in the treatment and the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

(i). Time to Produce Effect for all types of manipulative treatment: One to six treatments.

(ii). Frequency: Up to three times per week for the first three weeks as indicated by the severity of involvement and the desired effect.

(iii). Optimum Duration: 10 treatments.

(iv). Maximum Duration. 12 treatments.

Additional visits may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co-morbidities. Functional gains including increased ROM must be demonstrated to justify continuing treatment.

vii. Manual Electrical Stimulation is used for peripheral nerve injuries or pain reduction that requires continuous application, supervision, or involves extensive teaching. Indications include muscle spasm (including TENS), atrophy, decreased circulation, osteogenic stimulation, inflammation, and the need to facilitate muscle hypertrophy, muscle strengthening, muscle responsiveness in Spinal Cord Injury/Brain Injury (SCI/BI), and peripheral neuropathies.

(a). Time to Produce Effect: Variable, depending upon use.

(b). Frequency: Three to seven times per week.

(c). Optimum Duration: Eight weeks.

(d). Maximum Duration: Two months.

viii. Massage - Manual or Mechanical. Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by, or with, the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and ROM, or to increase muscle relaxation and flexibility prior to exercise. In cases with edema, deep vein thrombosis should be ruled out prior to treatment.

(a). Time to Produce Effect: Immediate.

(b). Frequency: One to two times per week.

(c). Optimum Duration: Six weeks.

(d). Maximum Duration: Two months.

ix. Mobilization (Joint) is a generally well-accepted treatment. Mobilization is passive movement which may include passive ROM performed in such a manner (particularly in relation to the speed of the movement) that it is, at all times, within the ability of the patient to prevent the movement if they so choose. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement/maltraction.

(a). Time to Produce Effect: Six to nine treatments.

(b). Frequency: Three times per week.

(c). Optimum Duration: Six weeks.

(d). Maximum Duration: Two months.

x. Mobilization (Soft Tissue) is a generally well-accepted treatment. Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, myofascial release, manual trigger point release and manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions. These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

(a). Time to Produce Effect: Two to three weeks.

(b). Frequency: Two to three times per week.

(c). Optimum Duration: Four to six weeks.

(d). Maximum Duration: Six weeks.

xi. Superficial Heat and Cold Therapy is a generally accepted treatment. Superficial heat and cold therapies are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It may be used acutely with compression and elevation. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm and promote stretching/flexibility. Includes portable cryotherapy units, and application of heat just above the surface of the skin at acupuncture points.

(a). Time to Produce Effect: Immediate.

(b). Frequency: Two to five times per week.

(c). Optimum Duration: Three weeks as primary, or up to two months if used intermittently as an adjunct to other therapeutic procedures.

(d). Maximum Duration: Two months.

xii. Transcutaneous Electrical Nerve Stimulation (TENS) is a generally accepted treatment. TENS should include at least one instructional session for proper application and use. Indications include muscle spasm, atrophy, and decreased circulation and pain control. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable functional improvement must be documented prior to the purchase of a home unit.

(a). Time to Produce Effect: Immediate.

(b). Frequency: Variable.

(c). Optimum Duration: Three sessions.

(d). Maximum Duration: Three sessions. If beneficial, provide with home unit or purchase if effective.

xiii. Ultrasound (including Phonophoresis) is an accepted treatment. Ultrasound includes ultrasound with electrical stimulation and phonophoresis. Ultrasound uses sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing.

(a). Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves a dispersive electrode placement. Indications include muscle spasm, scar tissue, and pain modulation and muscle facilitation.

(b). Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

(i). Time to Produce Effect: 6 to 15 treatments.

(ii). Frequency: Three times per week.

(iii). Optimum Duration: Four to eight weeks.

(iv). Maximum Duration: Two months.

15. Vocational Rehabilitation is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification of highest functional level, motivation and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation.

a. It may also be beneficial for full vocational rehabilitation to be started before MMI if it is evident that the injured worker will be unable to return to his/her previous occupation. A positive goal and direction may aid the patient in decreasing stress and depression, and promote optimum rehabilitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

### **§2327. Therapeutic Procedures—Operative**

A. All operative interventions must be based upon positive correlation of clinical findings, clinical course and

diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking operative conditions (e.g., peripheral neuropathy, myofascial pain, scleratogenous or sympathetically mediated pain syndromes, psychological), prior to consideration of elective surgical intervention.

B. In addition, operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.

C. Structured rehabilitation interventions should be strongly considered post-operative in any patient not making expected functional progress within three weeks post-operative.

D. Post-operative therapy will frequently require a repeat of the therapy provided pre-operatively. Refer to Therapeutic Procedures, Non-operative, and consider the first post-operative visit as visit number one, for the time frame parameters provided.

E. Return-to-work restrictions should be specific according to the recommendation in Therapeutic Procedures – Non-operative.

#### **1. Shoulder Replacement (Arthroplasty)**

a. Description/Definition. Prosthetic replacement of the articulating surfaces of the shoulder joint. There are three types of procedures commonly performed. The total shoulder component in which the glenoid and humeral head are replaced anatomically. The hemiarthroplasty which involves replacement of the humeral head only. The reverse arthroplasty where the head of the humerus is replaced by a prosthesis forming a socket and the glenoid is replaced with a ball prosthesis.

b. Occupational Relationship. Usually from post-traumatic arthritis, or from trauma resulting in severe humeral head fractures.

c. Specific Physical Exam Findings. Stiff, painful shoulder with limited function.

d. Diagnostic Testing Procedures: Radiographs or CTs demonstrating humeral head fracture. CTs or diagnostic arthroscopy to explore the status of rotator cuff and associated muscles and tendons, the presence of arthritis or subluxation, or superior migration of the humeral head. For revision procedures, a non-MRI arthrography or sonogram may be important to better visualize associated pathology.

e. Surgical Indications. The decision of whether a patient receives a total arthroplasty or a hemiarthroplasty depends on the surgeon's discretion. Factors to consider are the presence of glenoid erosions, humeral head subluxation and rotator cuff strength. There is good evidence that total arthroplasties compared to hemiarthroplasties results in improved function in primary osteoarthritis of the shoulder, and relief of pain two years post-operatively. Longer-term results are unknown.

i. Hemiarthroplasty may utilize a long stem humeral head replacement or a resurfacing device. It may

also be performed for humeral head fractures. It has been used for severe arthritis unresponsive to other treatments; however, there is some evidence that total shoulder arthroplasty may yield a better functional outcome. In younger active patients the eventual wear on the glenoid cartilage may cause decreased function over time. Total arthroplasty may therefore be preferred in many cases. Partial humeral head prosthesis may be useful in some cases. Cementless surface humeral head replacement may be indicated in young patients with glenohumeral arthritis and retained glenoid cartilage.

ii. Total shoulder arthroplasty is usually performed in cases of severe arthritis when all reasonable conservative measures have been exhausted without sufficient return to activities of daily living. Arthroscopic surgery may be considered in selected patients with a milder degree of arthritis. Arthroscopic SLAP repair is usually not recommended in cases of severe arthritis. The rotator cuff should generally be intact or repairable.

iii. Reverse arthroplasty is generally considered a salvage procedure for patients over 70 with severe osteoarthritis, massive rotator cuff tears and pseudo paralysis with integrity of the deltoid. Complications rates may be in the vicinity of 10 percent of patients within the first year following surgery. The long-term success of the prosthesis is not known at this time.

iv. Reverse prosthesis may also be the treatment for failed hemiarthroplasty with extensive cuff tears and/or instability. Most literature confirms that the complication rate is higher and the success rate lower when reverse arthroplasty is performed on a previously operated joint, however, many patients demonstrate good improvement with elevation, but not necessarily rotation. Bone loss may increase the complication rate.

v. Procedural complications may include humeral head subluxation or dislocation, humeral and/or glenoid loosening, rotator cuff tear, fractures, stiffness, painful glenoid erosion, transient nerve palsies, heterotopic ossification, bone loss, and component mal-positioning.

vi. Revision surgery may be performed by an orthopedic surgeon in cases with chronic pain and stiffness, painful glenoid erosion, or difficulty with activities of daily living. Prior authorization is required and a second opinion by a surgeon with special expertise in shoulder surgery should usually be performed. In the case of a total failure of the prosthesis, arthrodesis is the salvage procedure.

f. Operative Treatment: Prosthetic replacement of the articular surfaces of the shoulder.

g. Post-operative Treatment:

i. Individualized rehabilitation program based on communication between the surgeon and the therapist. Timing of passive motion and active rehabilitation is dependent on the type of procedures performed.

(a). Pool exercise initially under therapists or surgeon's direction then progressed to independent pool program.

(b). Progression to a home exercise is essential. Therapy should continue for at least 10 weeks with transition to home exercises at the beginning of each new phase of therapy.

(c). Gradual resistive exercise from 3 to 12 months, with gradual return to full activity at 6 to 12 months.

(i). Time frames for therapy (excluding pool therapy).

(ii). Optimum: 12 to 24 sessions.

(iii). Maximum: 36 sessions. If functional gains are being achieved additional visits may be authorized for the patient to achieve their functional goal.

ii. Reverse arthroplasty patients may have a more rapid rehabilitation in some cases. Per the recommendation of the surgeon the following therapies may take place: Sling use for the first three weeks, ADLs at three to six weeks, and then gentle strengthening.

iii. Should progress plateau the provider should reevaluate the patient's condition and make appropriate adjustments to the treatment plan. Other therapies may be employed in individual cases.

iv. Gradual return to full activity can occur between 6 to 12 months, depending on the procedure.

v. Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

2. Oats Procedure Osteoarticular allograft transplantation is a procedure which places a plug of cadaveric bone tissue into a chondral defect at the articular surface of an injured bone. Its use has been described in case reports in the treatment of recurrent shoulder instability when large humeral head defects (Hill-Sachs lesions) are thought to be responsible for repeated episodes of subluxation. At this time, there is limited information concerning its effectiveness and appropriate application. For this reason, it requires prior authorization as an isolated procedure with a second opinion by a surgeon with special expertise in shoulder surgery. The procedure may be used for isolated chondral/bony deficits involving the humeral head, including avascular necrosis. Partial humeral head prosthesis may be useful in some cases. (Refer to Hemi-arthroplasty)

3. Arthrodesis

a. Description/Definition:

i. Fusion of the shoulder. Used as a salvage procedure.

b. Occupational Relationship:

i. Secondary to severe trauma and failure of other procedures.

c. Specific Physical Exam Findings:

i. Shoulder function is minimal and is usually associated with severe rotator cuff pathology.

d. Diagnostic Testing Procedures:

i. See Specific Diagnostic sections.

e. Surgical Indications:

i. Inability to perform activities of daily living, failed previous procedures.

f. Operative Treatment:

i. Fusion.

g. Post-operative Treatment. An individualized rehabilitation program based upon communication between the surgeon and the therapist. Therapy may begin 6 weeks to 3 months depending on recovery. Occupational therapy is critical to improve function in activities of daily living. Assistive devices may be necessary.

i. Time frames for therapy (excluding pool therapy).

ii. Optimum: 12 to 24 sessions.

iii. Maximum: 36 sessions. If functional gains are being achieved additional visits may be authorized for the patient to achieve their functional goal.

4. Manipulation Under Anesthesia (Refer to Adhesive Capsulitis/Frozen Shoulder Disorder)

5. Hardware Removal

a. Description/Definition:

i. Surgical removal of internal or external fixation device, commonly related to fracture repairs.

b. Occupational Relationship:

i. Following healing of a post-traumatic injury that required fixation or reconstruction using instrumentation.

c. Specific Physical Exam Findings:

i. Local pain to palpation, swelling, erythema.

d. Diagnostic Testing Procedures:

i. Radiographs, tomography, CT scan, MRI.

e. Non-operative Treatment:

i. Active and/or passive therapy for local modalities, activity modification. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs).

f. Surgical Indications:

i. Persistent local pain, irritation around hardware.

g. Operative Treatment:

i. Removal of instrumentation may be accompanied by scar release/resection, capsular release, and/or manipulation. Some instrumentation may be removed in the course of standard treatment without local irritation.

h. Post-operative Treatment:

i. Include an individualized rehabilitation program based upon communication between the surgeon and the therapist.

ii. Early rehabilitation interventions are recommended to maintain range-of-motion and progressive strengthening.

(a). Frequency – Three to five times per week for the first two weeks, three times per week for the following two weeks, then one to two times per week.

(b). Optimum Duration for six to eight weeks with progression to home exercise and or pool therapy.

(c). Maximum Duration – 12 weeks. Occasional follow-up visits may be justified to reinforce exercise patterns, or to reach final functional goals if the therapy to date has demonstrated objective functional gains.

(d). Return to work and restrictions after surgery may be made by an experienced primary occupational medicine physician in consultation with the surgeon or by the surgeon.

5. Human Bone Morphogenetic Protein (RhBMP) is a member of a family of proteins which are involved in the growth, remodeling, and regeneration of bone tissue. It has become available as a recombinant biomaterial with osteo-inductive potential for application in long bone fracture non-union and other situations in which the promotion of bone formation is desired. In the treatment of non-union of fractures of the humerus and clavicle, no controlled clinical trials have been conducted as of this date, though small case series have resulted in union of some fractures. Ectopic

ossification into adjacent muscle has been reported to restrict motion in periarticular fractures. Due to lack of information on the incidence of complications and overall success rate, its use requires prior authorization. It should be used principally for non-union of fractures that have not healed with conventional surgical management or peri-prosthetic fractures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

**§2328. LWC-WC 1009. Disputed Claim For Medical Treatment**

Mail to:

OWCA—Medical Services  
ATTN: Medical Director  
P.O. Box 94040  
Baton Rouge, LA 70804

- 1. Social Security No. \_ \_ - \_ - \_
- 2. Date of Injury/Illness \_ - - \_ - \_
- 3. Parts of Body Injury \_\_\_\_\_
- 4. Date of Birth \_ - - \_ - \_
- 5. Date of This Request \_ - - \_ - \_
- 6. Claim Number \_\_\_\_\_

**DISPUTED CLAIM FOR MEDICAL TREATMENT**

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THE INSURER HAS ISSUED A DENIAL FOR THE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J.

**GENERAL INFORMATION**

Claimant files this dispute with the Office of Workers' Compensation – Medical Services Director. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by  
\_\_\_ Employee \_\_\_ Employer \_\_\_ Insurer \_\_\_ Health Care Provider \_\_\_  
Other \_\_\_

A. Copies of all relevant medical records must be included with this request.

B. A copy of the denial letter issued by the insurance carrier must be attached to this request.

**EMPLOYEE**

8. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

**EMPLOYEE'S ATTORNEY**

9. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER**

10. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**INSURER/ADMINISTRATOR**

(circle one)  
11. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**EMPLOYER/INSURER'S ATTORNEY**

12. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

**TREATING/REQUESTING PHYSICIAN**

13. Name \_\_\_\_\_  
Street or Box \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_\_

LWC-WC 1009  
11/2010

14. PLEASE PROVIDE A SUMMARY OF THE DETAILS REGARDING THE ISSUE AT DISPUTE:

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You may attach a letter or petition with additional information with this disputed claim.

The information given above is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
SIGNATURE OF REQUESTING PARTY

\_\_\_\_\_  
DATE

LWC-WC 1009  
11/2010

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:

Inquiries concerning the proposed enactment may be directed to Director, Office of Workers' Compensation Administration, Louisiana Department of Labor, P.O. Box 94040, Baton Rouge, LA 70804-9040.

Curt Eysink  
Executive Director

1012#019

# Rules

## RULE

### Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences

#### Giant Salvinia (LAC 7:XXIII.143)

In accordance with the Administrative Procedure Act, (R.S. 49:950 et seq.), and under the authority of R.S. 3:3203, the Department of Agriculture and Forestry has amended these rules and regulations for the implementation of a herbicide application program by the Sabine River Authority, State of Louisiana (SRA) to manage the noxious aquatic weed Giant Salvinia in the Toledo Bend Reservoir (Toledo Bend). The SRA's herbicide application program will allow Louisiana property owners whose property adjoins Toledo Bend to apply certain herbicides to control Giant Salvinia in, on and around their property.

The SRA, the Louisiana Department of Wildlife and Fisheries, (LDWF), the LSU Agricultural Center (Ag Center), the Toledo Bend Residents Association, and Bass Unlimited have requested the adoption of these rules to allow for the spraying and controlling Giant Salvinia at Toledo Bend. Giant Salvinia was first discovered on Toledo Bend in 1998 and has proliferated to the point that it threatens the native plants and animals that live in the lake, the biodiversity of that aquatic life, the continued commercial and recreational use of the lake and the productivity and usefulness of the lake itself. The Rule will provide an effective program for controlling Giant Salvinia at Toledo Bend.

#### Title 7

### AGRICULTURE AND ANIMALS

#### Part XXIII. Pesticides

#### Chapter 1. Advisory Commission on Pesticides

#### Subchapter I. Regulations Governing Application of Pesticides

#### §143. Restrictions on Application of Certain Pesticides

##### A. - L.2. ...

M. The commissioner hereby establishes a herbicide application permitting program for the Sabine River Authority, State of Louisiana (SRA) in, on and around the waters of the Louisiana portion of Toledo Bend Reservoir.

1. Any person who applies or uses any herbicide or incorporates the use of any herbicide, for the management, control, eradication or maintenance of Giant Salvinia in, on or around the waters of the Louisiana portion of Toledo Bend Reservoir, shall comply with all of the following requirements, prior to making any applications to Giant Salvinia in SRA waters.

a. Complete the SRA designated Giant Salvinia applicator training program.

b. Apply for and receive a herbicide application permit from the SRA which shall be good for the remainder of the calendar year in which issued, but may be renewed annually by contacting the SRA.

c. Apply, use, or incorporate herbicides to be applied to or used on or for Giant Salvinia only as prescribed by the SRA herbicide application program.

d. Prepare and maintain records of applications by recording accurate information as required on the Toledo Bend application log sheet provided by the SRA.

e. Deliver (mail, hand deliver, e-mail, fax, etc.) to the SRA office at Pendleton Bridge Office, 15091 Texas Highway, Many, LA 71449 a completed copy of each Toledo Bend application log sheet recording the information regarding an application or use of a herbicide on or for Giant Salvinia within 14 days of each application.

f. Keep a completed copy of the application record form for a period of three years after application.

g. Make application records available, during normal business hours, to any authorized person with the department, Department of Wildlife and Fisheries or the SRA.

2. Any person making applications to the Louisiana portion of Toledo Bend Reservoir under contract with the LDWF or SRA, authorized LDWF employees and any person conducting a research project on the Louisiana portion of Toledo Bend Reservoir with the LSU Agricultural Center, LDWF or SRA is exempted from the provisions of this Subsection, but are not excepted from any other provisions of this Part, except as may be provided therein.

N. - O.5.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3203, R.S. 3:3242 and R.S. 3:3249.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Advisory Commission on Pesticides, LR 9:189 (April 1983), amended LR 10:196 (March 1984), LR 11:219 (March 1985), LR 11:942 (October 1985), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, LR 18:953 (September 1992), LR 19:1119 (September 1993), LR 21:668 (July 1995), LR 24:281 (February 1998), LR 24:2076 (November 1998), LR 26:1428 (July 2000), LR 26:1966 (September 2000), LR 27:279 (March 2001), LR 27:1672 (October 2001), LR 33:1855 (September 2007), LR 35:628 (April 2009), LR 37:269 (January 2011).

Mike Strain, DVM  
Commissioner

1101#071

## RULE

### Department of Agriculture and Forestry Office of Agricultural and Environmental Sciences Seed Commission

#### Labeling of Coated Seeds (LAC 7:XIII.121)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., and with the enabling statute, R.S. 3:1433, the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, has amended this regulation to provide the requirements for the labeling of coated seed so that

purchasers of these seeds can be informed of the percent by weight of seed and non-seed material before making the purchase.

**Title 7**  
**AGRICULTURE AND ANIMALS**  
**Part XIII. Seeds**

**Chapter 1. Louisiana Seed Law**  
**Subchapter A. Enforcement of the Louisiana Seed Law**  
**§101. Definitions**

A. ...

*Coated Seed*—any seed unit covered with any substance that changes the size, shape, or weight of the original seed. Seeds coated with ingredients such as, but not limited to, rhizobia, dyes, and pesticides that do not significantly change the size, shape, or weight of the original seed are excluded.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1431 and R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Seed Commission, LR 4:104 (April 1978), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 12:825 (December 1986), LR 36:1220 (June 2010), LR 37:270 (January 2011).

**§121. Labeling of Seed**

A. - A.3.b.ii. ...

4. For coated seed, the product must be identified on the label as “coated seed” and the percent by weight of seed and non-seed material must appear on the front of each package, adjacent to the product name. The listing of the percentages must be in a size type that will permit the ultimate purchaser to read the information easily and without strain.

a. This provision shall go into effect on December 31, 2011.

B. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433 and 3:1436.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Seed Commission, LR 4:105 (April 1978), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 12:825 (December 1986), LR 16:492 (June 1990), LR 37:270 (January 2011).

Mike Strain, DVM  
Commissioner

1101#072

**RULE**

**Department of Agriculture and Forestry**  
**Office of the Commissioner**

Louisiana Strawberries (LAC 7:V.1901-1935)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., and with the enabling statute, R.S. 3:730.4 and 3:730.8, the Department of Agriculture and Forestry, has amended and repealed rules and regulations to provide for the administration of the Louisiana Strawberry Marketing Board, to bring the rules and regulations regarding the assessment on strawberries sold in this state

into line with current law and to implement Act 40 of the 2010 regular session of the legislature.

The action will establish rules and regulations regarding administrative matters of the Strawberry Marketing Board, which current regulations do not provide for. The current regulations regarding the payment of assessments were promulgated in 1991 based on an assessment on pint containers of strawberries that was in existence at the time. That assessment was repealed by Act 1253 of 2003 and replaced by Act 1253 with the current assessment on strawberries produced or sold in this state. The proposed action repeals and amends the current rules and regulations to reflect the change in the assessment. This action will also adopt rules and regulations implementing Act 40 of 2010 which requires identification of the farm of origin of strawberries offered for sale in this state.

**Title 7**

**AGRICULTURE AND ANIMALS**

**Part V. Advertising, Marketing and Processing**

**Chapter 19. Louisiana Strawberries**

**Subchapter A. General Provisions**

**§1901. Definitions**

A. The words and terms defined in R.S. 3:730.2 are applicable to this Chapter.

B. The following words and terms are defined for the purposes of this Chapter.

*Container or Package*—the receptacle in which strawberries are placed or held for retail sale.

*Farm of Origin*—the tract of land on which the strawberries in a container were raised.

*Handler of Strawberries*—a person, except for a producer and an ultimate purchaser, who, for a profit, processes, packs, distributes, markets, or sells strawberries in this state.

*Louisiana Grown Strawberries*—strawberries that are raised, processed, and packed entirely in Louisiana.

*Producer*—a person who commercially raises and harvests strawberries for sale.

*Ultimate Purchaser*—the person or consumer who will eat the strawberries and the last person in the chain of distribution who removes the strawberries from the container and prepares them to be eaten by a consumer. A restaurant shall be considered to be an ultimate purchaser.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:249 (March 1991), amended by the Office of the Commissioner, LR 37:

**§1903. Records Required; Inspections and Audits**

A. Each Louisiana producer and each handler of fresh or frozen strawberries in this state shall maintain complete, separate and correct records and accounts pertaining to all lots of strawberries produced, processed, packed, distributed, marketed or sold in this state, including, but not limited to, bills of lading, warehouse receipts, invoices, sales receipts, the person the strawberries were received from, the person the strawberries were delivered to, the number or amount of strawberries, whether kept by weight, measure, or count, and any Louisiana strawberry assessment paid or collected.

B. Each producer and handler of strawberries in Louisiana shall permit any authorized officer, employee, or representative of the department or the board to enter and inspect all locations where strawberries or records are kept

and to examine and audit all records, books, and accounts relating to the producing and handling of strawberries in this state.

C. Any such inspection, examination or audit may be made on any business day, during normal working hours and the producer or handler shall provide the necessary assistance and cooperation required for the completion of the inspection, examination, or audit.

D. No person shall in any way interfere with an authorized officer, employee, or representative who is entering or inspecting, or attempting to do so, a location where strawberries or records relating to strawberries are kept or is examining or auditing, or attempting to do so, records, books, and accounts relating to the producing and handling of strawberries in this state.

E. All required records shall be kept for a period of three years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended by the Office of the Commissioner, LR 37:271 (January 2011).

#### **§1905. Collection**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:475, repealed in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended LR 17:955 (October 1991), repealed by the Office of the Commissioner, LR 37:271 (January 2011).

#### **§1907. Records**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:475, repealed in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended LR 17:956 (October 1991), repealed by the Office of the Commissioner, LR 37:271 (January 2011).

#### **§1909. Authority of Agents to Enter Premises**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:475, repealed in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended LR 17:956 (October 1991), repealed by the Office of the Commissioner, LR 37:271 (January 2011).

#### **§1911. Refunds**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:475, repealed in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended LR 17:956 (October 1991), repealed by the Office of the Commissioner, LR 37:271 (January 2011).

#### **§1913. Penalties**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:475 and R.S. 3:478, repealed in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, State Market Commission, LR 17:250 (March 1991), amended LR 17:956 (October 1991), repealed by the Office of the Commissioner, LR 37:271 (January 2011).

### **Subchapter B. The Strawberry Marketing Board**

#### **§1921. Compensation of Board Members**

A. The board may waive the compensation provided by law for members by unanimous consent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 37:271 (January 2011).

#### **§1923. Board Meetings**

A. The board shall meet at least once in every quarter of the year, but a meeting may be cancelled by the chairman if there is no business to consider at the meeting.

B. The board shall meet upon the call of the chairman or the commissioner or upon the written request of at least three board members.

C. The board shall not meet more than 12 times in any one year.

D. The meetings shall be conducted in accordance with Roberts Rules of Order, Newly Revised, 10th Edition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:730.4.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 37:271 (January 2011).

### **Subchapter C. Farm of Origin Labeling**

#### **§1931. Labeling of Strawberries**

A. Each container of fresh or frozen strawberries sold or offered for sale in this state to the ultimate purchaser shall have a stamp or label containing sufficient information from which the farm of origin may be identified, except as otherwise provided by these regulations.

B. The identifying information may be provided by one of the following methods.

1. Identification of the name and address of the producer, processor, or distributor pursuant to Section 101.5 of Title 21 the Code of Federal Regulations.

2. Placement of the name and address of the farm of origin on a stamp or label on the top or side of the container.

3. Use of a brand name along with a recordkeeping or traceability system that permits the identification of the farm of origin.

4. Providing a bar code on the stamp or label that permits the strawberries to be traced back to the farm of origin.

5. Any other method that provides a reasonable means of tracing the strawberries back to the farm of origin.

C. The identifying information shall be provided in indelible ink or print and in a form that is legible to a reasonable person and that will remain affixed to the container or covering until removed by the ultimate purchaser.

D. The stamp or label may also state "Louisiana Strawberries," "Product of Louisiana" or other words or phrases that indicate that the strawberries are Louisiana grown strawberries unless the use of the name or phrase would constitute a prohibited use of a logo of the department, or use a logo provided by the department if such use is authorized by these regulations.

E. Strawberries may be sold in open or unwrapped containers at a roadside stand, farmer's market, fair or

festival, or other similar location without the identifying information being on each container only if:

1. a sign that is readable by a reasonable person, without strain, is posted with the strawberries stating the name and address of the farm of origin; and

2. a bill of sale, invoice, or some other document that would allow the strawberries to be traced back to the farm of origin is at the location and available for inspection by an authorized office, employee, or representative of the board or the department.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:730.4 and 3:730.8.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 37:271 (January 2011).

### **§1933. Louisiana Grown Strawberries; Use of Department Logos**

A. Louisiana grown strawberries may be eligible for labeling with a logo developed by the department for use on strawberries or other agricultural products raised, processed, and packed in this state.

B. Any producer, processor, packer, wholesaler, or distributor who desires to have a logo of the department placed on containers of Louisiana grown strawberries may register with the department for participation in a logo use program.

C. All farms of origin that provide the strawberries sold or offered for sale by the participating producer, processor, packer, wholesaler, or distributor shall be registered with the department before approval to use the logo is given by the department.

D. The application for participation shall be submitted in writing to the department on a form approved by the department.

E. Upon approval, the applicant shall have the right to affix a logo of the department on all containers of strawberries.

F. A logo of the department may not be placed on any container of strawberries that holds any strawberries that are raised, processed, or packed in another country or another state.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:730.4 and 3:730.8.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 37:272 (January 2011).

### **§1935. Use of Containers Ordered Prior to the Effective Date of these Regulations**

A. Any person who prior to the effective date of these regulations ordered strawberry containers that do not meet the requirements of these regulations may use those containers for the 2011 strawberry season up to July 1, 2011 if documentation allowing the farm of origin to be determined is available for inspection by an authorized officer, employee, or representative of the board or the department.

B. In no event shall any container that does not comply with the labeling requirements of this Subchapter be used after July 1, 2011, except as allowed by §1931.E of this Part.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 3:730.4 and 3:730.8.

**HISTORICAL NOTE:** Promulgated by the Department of Agriculture and Forestry, Office of the Commissioner, LR 37:272 (January 2011).

Mike Strain, DVM  
Commissioner

1101#070

## **RULE**

### **Department of Agriculture and Forestry Structural Pest Control Commission**

Structural Pest Control Commission  
(LAC 7:XXV.Chapter 1)

In accordance with the Administrative Procedure Act, (R.S. 49:950 et seq.), and under the authority of R.S. 3:3366, the Department of Agriculture and Forestry, Structural Pest Control Commission is adopting these amendments and revisions to the rules and regulations of the Commission to make technical corrections, define and clarify certain terms, provide homeowners and pest control operators a clearer understanding of the requirements for treating in all phases of pest control, and to modernize and update these rules and regulations to reflect changes in the structural pest control industry.

## **Title 7**

### **AGRICULTURE AND ANIMALS**

#### **Part XXV. Structural Pest Control**

##### **Chapter 1. Structural Pest Control Commission**

##### **§101. Definitions**

A. The definitions in R.S. 3:3362 are applicable to this Part.

B. The following words and terms are defined for the purposes of this Part.

*Act*—the Structural Pest Control Law, which is currently Part VII of Chapter 20 of Title 3 of the Louisiana Revised Statutes of 1950, (R.S. 3:3301 et seq.).

*Adjudicatory Proceeding*—an open public hearing by the commission to determine whether violations of the Act or these rules and regulations have occurred.

*Applicant*—any person making application for a license to engage in operations coming under the provisions of this Part.

*Availability* [with reference to *direct supervision*]—that the licensee must be able to reach the job site within three hours after receipt of a call or have established another licensee to supervise his operations (see definition of *direct supervision* in §101).

*Bond*—a written instrument issued or executed by a bonding, surety or insurance company licensed to do business in this state, guaranteeing the fulfillment of the agreement between the licensee or business entity and his customer and insuring against fraudulent practices by the licensee or business entity.

*Branch Office*—any site, i.e., office, store, warehouse, etc., where any kind of structural pest control services are offered to the general public.

*Business*—either a single person or a group of persons organized to carry on the business of structural pest control.

*Certified Applicator* (for purposes of these regulations)—any person who holds a valid license as herein provided or otherwise known as licensee.

*Certified Fumigation Technician*—a technician qualified to perform the following:

a. *Structural Fumigation*—apply fumigants to and clear fumigants from structures under the supervision of a licensed fumigator.

b. *Ship Fumigation*—shall only add additional fumigants to a ship fumigation after the initial amount of gas fumigants has been applied, under the supervision of a licensed fumigator.

c. *Commodity Fumigation*—apply fumigants to and clear fumigants from commodities under the supervision of a licensed fumigator.

*Chain Wall*—any wall constructed of any material that supports or skirts a structure.

*Commodity Fumigation*—the fumigation of food or non-food items stored in stacks, rail cars, containers, trucks, barges, boxes, bins, etc. that are not normally occupied by humans. No living quarters shall be in any of the above.

*Construction*—the act of building a structure from the start of the first stage of physical work until completion which is when either the structure is ready to be inhabited, final inspection and approval by an appropriate building inspector, or completion of the final grade.

*Contract*—a written agreement between two or more persons, one of whom is a pest control operator for services for the provision of a specific pest control service. Contracts for subterranean termites, dry wood termites, powder post beetles or old house borers shall be approved by the Commission prior to use.

*Curtain Wall*—any non-supporting wall constructed of any material that skirts a structure.

*Department*—the Louisiana Department of Agriculture and Forestry.

*Direct Supervision*—physical contact at least twice within five consecutive working days by a licensee with all employees registered under his supervision, including giving routine and/or special instructions, prescribing pesticides, calculating volume of pesticides to be applied, calibrating equipment and being available, whenever and wherever needed, to handle any emergency situations which might arise (see definition of *availability* in §101).

*Director*—the director of the Division of Pesticide and Environmental Programs or his duly authorized representatives acting at his direction.

*Division*—the Department's Division of Pesticide and Environmental Programs.

*Employee*—any person employed by a permittee and working under the supervision of licensee with the exceptions of clerical, janitorial or office maintenance employees or those employees performing work completely disassociated with the use of pesticides, the control and inspection of insects, pests, rodents and the control of and inspection for wood-destroying insects.

*Fumigation*—the application of a fumigant in residential and commercial structures, ships, railcars, trucks, commodities such as dunnage on wharves, silos or conveyors, vaults or the like.

*Gas*—matter in a vapor state which diffuses readily and is capable of indefinite expansion in all directions moving

from an area of high concentration toward an area of lower concentration. Aerosols should not be confused with gas as they are particulate suspensions.

*Household Pest*—all species of insects and other pests which infest residences and other types of buildings and their immediate premises, such as cockroaches, flies fleas, mosquitoes, clothes moths, spiders, carpenter ants, carpenter bees, rodents and so forth, but does not include wood-destroying insects.

*Label*—the written, printed or graphic matter on or attached to a pesticide or device or any of its containers or wrappers.

*Labeling*—all labels and other written, printed or graphic matter:

a. accompanying a pesticide or device at any time; or

b. to which reference is made on the label or in literature accompanying the pesticide or device, provided that the term does not apply to current official publications of the EPA; the U.S. Departments of Agriculture, Interior or Health, Education and Welfare; state experiment stations; state agriculture colleges; and other similar federal and state institutions and agencies authorized by law to conduct research in the field of pesticides.

*License*—a document issued by the commission which authorizes the practice and/or supervision of one or more phases of structural pest control work as follows:

a. *General Pest Control*—the application of remedial or preventive measures to control, prevent or eradicate household pests by use of pesticides used as sprays, dusts, aerosols, thermal fogs, barriers, traps and baits. Residential rodent control will be limited to the use of anticoagulant rodenticide and traps;

b. *Commercial Vertebrate Control*—the application of remedial or preventive measures to control, prevent or eradicate vertebrates, including baits, chemicals, barriers, gases and traps, in nonresidential establishments, but not including tarpaulin fumigation;

c. *Termite Control*—the application of remedial or preventive measures for the control, prevention or eradication of termites and other wood-destroying insects and the inspection of structures for wood-destroying insects;

d. *Fumigation*—the use of lethal fumigants and/or rodenticides in a gaseous form for the control, prevention or eradication of insect pests, rodents, or other pests in a sealed enclosure with or without a tarpaulin;

e. *Wood Destroying Insect Report (WDIR) Inspector*—the application of remedial or preventive measures for the control, prevention or eradication of termites and other wood-destroying insects and the inspection of structures for wood-destroying insects.

*Licensee*—the person who holds a valid license as herein provided.

*Material Safety Data Sheet (M.S.D.S.)*—a document which states chemical characteristics and safety precautions regarding a specific chemical.

*Non-Residential Establishment*—includes, but shall not be limited to, hotels, motels, schools, hospitals and nursing homes.

*Permittee*—any person who holds a place of business permit issued by the commission.

*Pest Control Operator*—any person conducting or performing structural pest control.

*Place of Business*—the entire premises to which the public generally is expressly or impliedly invited for the purpose of transacting business with the owner and is simply a location where business is transacted, or a shop, office, warehouse or commercial establishment, and shall be indicated on the application and the permit and any license issued for that place of business.

*Registered Employee*—an employee registered as provided by this Chapter.

*Registered Wood Destroying Insect Report (WDIR) Technician*—an employee qualified to conduct wood destroying insect report inspections.

*Registration Certificate*—a document issued by the commission staff to a non-licensed employee of a business engaged in structural pest control work.

*Repellents*—substances, not fumigants, under whatever name known, which may be toxic to insects and related pests, but generally employed because of their capacity for preventing the entrance or attack of pests.

*Residential Structure*—any structure, movable or immovable, permanent or temporary, that is adapted for both human residence and lodging whether occupied or not, such as, single-family homes, multi-family, apartments, townhouses, condominiums, and/or co-ops but excludes any structure built for the temporary residence of a human such as hotels, motels.

*Secretary or Secretary of the Commission*—the Assistant Commissioner of Agricultural and Environmental Sciences (assistant commissioner).

*Ship Fumigation*—the fumigation of a vessel capable of transporting or housing people and/or products. It is normally self-powered and shall have a crew or living quarters.

*Spot Treatment* (when used in reference to termite control work)—a localized application of chemicals or other substances to control, prevent or eradicate termites in a residence or other structure that is not under a current contract.

*Structural Fumigation*—the fumigation by covering or sealing churches, schools, homes or any other buildings in which people are normally housed or work or is frequented by people. This also includes the covering or sealing of small boats or ships under 100 feet.

*Termites*—all species of the order *Isoptera* which infest timbers and/or other materials containing cellulose in buildings and/or contents thereof, subdivided into two groups according to their habits, as follows:

a. *Subterranean Termites*—all species of termites which make tubes, but not pellets, and normally require contact with soil; especially species of the genera *reticulitermes* and *coptotermes*;

b. *Dry-Wood Termites*—all species of termites which make pellets, but not tubes, and do not require contact with damp soil; especially species of the genera *kalotermes*, *cryptotermes* and *incisitermes*.

*Termiticide*—any substance applied to buildings, wood products or soil for the treatment of termites.

*Termiticide Treatment*—application of a termiticide.

a. *Pre-Construction Treatment*—a termiticide treatment for subterranean termites made with a commission

approved termiticide prior to the stage of construction where a slab or concrete is poured or piers are being built or placed into position. Borate treatments during any stage of construction shall be considered a pre-construction treatment.

b. *New-Construction Treatment*—a termiticide treatment made with any commission approved termiticide(s) or baiting system that meets minimum specification requirements for that type of treatment and which is applied or installed during or after the stage of construction where a slab or concrete is poured or piers are being built or placed into position and up to 12 months after completion of construction. New-construction treatments are to be made in accordance with the post-construction treatment section of termiticide labels.

c. *Post-Construction Treatment*—a termiticide treatment made with any commission approved termiticide(s), using the post construction section of a label, which is applied after the time frame of new-construction.

*Vertebrate*—those pests, such as rodents, bats and birds, belonging to the phylum vertebrata.

*Violation*—any act which is prohibited by the Act or any of these rules and regulations. Violations shall be classified in accordance with degree of severity, as follows:

a. *Minor Violation*—any act prohibited by the Act or these rules and regulations which does not result in danger to human health or damage to personal property, including, but not limited to, clerical errors or failure to make timely reports to the commission;

b. *Moderate Violation*—any act of negligence in meeting the guarantees of an agreement for structural pest control work in the licensure phase where the violation occurs, such as failure to apply chemicals in accordance with label and labeling requirements and minimum specifications:

c. *Major Violation*—any act which may adversely affect human health and safety. Any act performed without having the proper permit, license, or registration; any intentional misrepresentation of any matter involved in or related to structural pest control work; or any false or misleading statement knowingly made in a wood-destroying insect report or any failure to timely pay any civil penalty imposed by the commission or any failure to timely pay any fee collected by the department.

*Wood Destroying Insect Report*—any document approved by the Structural Pest Control Commission issued by a pest control operator which pertains to wood-destroying insects, but not including a bid, a proposal or a contract for any structural pest control services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:323 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission LR 15:954 (November 1989), 17:251 (March 1991), LR 23:855 (July 1997), LR 30:1143 (June 2004), amended by the Department of Agriculture and Forestry, Office of Agriculture and Environmental Sciences, LR 31:26 (January 2005), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 32:796 (May 2006), repromulgated LR 32:1015 (June 2006), amended LR 33:39 (January 2007), LR 35:204 (February 2009), LR 35:1468 (August 2009), LR 37:272 (January 2011).

**§103. Administration of the Affairs of the Commission; Adoption of Rules and Regulations**

A. As provided by R.S. 3:3364, the commissioner or his designee shall serve as permanent chairman of the commission.

B. The assistant commissioner shall serve as secretary of the commission.

C. In the absence of the chairman, the secretary shall preside at meetings of the commission.

D. The chairman shall designate a hearing officer, who may or may not be a member of the commission, to preside at all adjudicatory proceedings of the commission.

E. The commission shall serve as the hearing body in all adjudicatory proceedings and shall make the final decision with regard to the disposition of matters coming to adjudication.

F. The commission shall hold regular meetings at least once during each quarter.

G. Meetings of the commission shall normally be held in the domicile of the commission.

H. Meetings may be held at locations other than the domicile of the commission upon the determination of the chairman or at the written request of any three members of the commission.

I. Special meetings of the commission may be called at any time by the chairman.

J. Whenever at least three members of the commission desire to call a special meeting, the three members shall so advise the chairman in writing and the chairman shall call a special meeting to be held within 30 days after receipt of the members' request.

K. If the chairman fails or refuses to call a special meeting upon the proper request of three members, the members may convene a special meeting of the commission by written notice to the remaining members.

L. The secretary shall notify each member of the commission by in writing or by electronic means of any regular or special meeting at least one week prior to the meeting date.

M. The secretary shall provide clerical and other support services as may be required by the commission and shall maintain and distribute appropriate minute records of all meetings of the commission.

N. There shall be no voting by proxy.

O. Three members of the commission shall constitute a quorum, and no action shall be taken without three votes in accord.

P. Rules and regulations of the commission, and amendments thereto, shall be noticed, adopted and promulgated as required by the Administrative Procedure Act.

Q. In addition to the requirements of the Administrative Procedure Act, the commission shall also provide prior written notice of any public hearing for consideration for adoption and/or amendment of any rules and regulations to all licensees at the last address reported by each licensee at least seven days prior to any such hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3363, R.S. 3:3364 and R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:325 (April 1985), amended by the Department of Agriculture and Forestry,

Structural Pest Control Commission, LR 20:644 (June 1994), LR 35:204 (February 2009), LR 37:275 (January 2011).

**§105. Permit for Operation of Structural Pest Control Business; Changes in Structural Pest Control Business**

A. Every place of business engaged in structural pest control work shall:

1. obtain a permit for operation from the commission prior to engaging in structural pest control work.

2. provide a certificate of insurance on a document provided by the department including but not limited to the following information:

a. not less than \$250,000, general liability coverage, per occurrence for the following:

i. all work performed under specific structural pest control license phases;

b. not less than \$100,000 coverage for property damage;

c. or combined single limits of \$350,000;

d. definitions for purposes of this Section:

i. *Public Liability*—general liability;

ii. *Accident*—occurrence;

e. provide at least 10 days prior written notice to the commission before cancellation and 10 days written notice to the commission when paid claims reach or exceed the aggregate limit.

3. Provide evidence of a surety or fidelity bond on a form provided by the department covering the business with which the applicant is connected, issued by a bonding, surety or insurance company authorized to do business in Louisiana, in the amount of \$2,000, of tenor and solvency satisfactory to a majority of the commission. An applicant who is not connected with a business covered by the required surety or fidelity bond shall secure the appropriate coverage prior to issuance of the license.

B. No permit for operation shall be issued by the commission unless there is a licensee for each phase of structural pest control work being conducted who is domiciled and designated as the primary licensee at the business location for which the permit is sought.

C. Each permit for operation shall be renewed annually, on or before June 30 of each year.

D. The fee for issuance of a permit for operation shall be \$125 for firms which employ two or less employees and \$175 for firms which employ three or more employees.

E. When two or more businesses which are separate legal entities, even though owned by the same individual or the same legal entity, are operated at one physical location, each separate entity shall obtain a permit for operation.

F. Whenever a license is suspended or revoked under §131, the commission may also revoke the permit to operate. In such cases, the commission shall recall the permit and require the licensee to immediately return the permit to the commission.

G. Whenever a permit is recalled by the commission as provided in §105.F, no structural pest control work of any kind shall be provided by persons domiciled at the location for which the recalled permit has been issued.

H. Except as provided in this Subsection, any change in the status of a permittee (e.g., death, retirement, prolonged illness, merger, sale, change of ownership, etc.) shall be

reported to the commission, in writing, within 14 days after the change in status occurs.

1. If the change in the permittees status would result in the non-renewal of the place of business permit or would require the commission to issue a new place of business permit, then the notice shall be accompanied by the following information:

a. the reason for the change in the status and the effective date of the change;

b. the status of all licensee(s) and registered and certified technicians;

I. If a permittee sells or otherwise transfers any wood destroying insects contract then the commission and each customer whose contract was sold or transferred shall receive the following written notification.

1. The selling or transferring permittee and the person purchasing or receiving the wood destroying insects contract shall each provide the commission in writing the following information and statements.

a. If all the wood destroying insects contracts of the permittee selling or transferring such contracts are being purchased or transferred then a statement that all wood destroying insects contracts are being sold or transferred and that all the contracts shall remain in full force and effect in accordance with the terms and conditions of the customers' contracts shall be sufficient.

b. If all the wood destroying insects contracts are not being sold or transferred then the information provided to the commission shall include:

i. a statement that all wood destroying insects contracts are being sold or transferred except for the specific contracts listed;

ii. a list of the specific contracts that are not being sold or transferred;

iii. for each contract being sold or transferred, a statement that all contracts being sold or transferred shall remain in full force and effect in accordance with the terms and conditions of the customers' contracts.

2. The person acquiring a wood destroying insects contract by a sale or transfer shall notify the customer in writing, within 30 days after the sale or transfer of:

a. the effective date of the sale, transfer, or change in status; and

b. the name, address, and telephone number of the person acquiring the customer's wood destroying insects contract;

c. a statement that the customer's contract shall remain in full force and effect in accordance with the terms and conditions of the contract.

J. A permittee who is closing his business or is otherwise not going to honor or service existing wood destroying insects contracts shall, within 14 days of the time of the close of business or ceasing to honor or service existing wood destroying insects contracts shall provide certified written notification of the decision to affected customers along with the following information:

1. the commission's address and telephone number;

2. the date of closure or last date the contract will be honored or serviced;

3. a statement of bond coverage; and

4. the bond company's name, address, telephone number, and contact person.

K. Any person who fails to comply with the provisions of this Section shall personally come before the commission prior to that person being granted a registration, certification, license, or permit, or renewal thereof. The commission may deny or defer action on a request to grant a registration, certification, license or permit, or renewal thereof. The commission may deny a renewal or impose civil penalties for violation of this Section only after the person has been brought to an adjudicatory proceeding and found guilty of violating the provisions of this Section.

L. All information and all documents relating to written contracts transmitted to the commission in accordance with the requirements of this Section shall be confidential and shall be exempt from the Public Records Law, R.S. 44:1 et seq., as provided in R.S. 3:3370.E.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:325 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:954 (November 1989), LR 33:40 (January 2007), LR 37:275 (January 2011).

### **§107. License to Engage in Structural Pest Control Work Required**

A. No person shall perform structural pest control work until licensed and permitted to do so by the commission.

B. Each applicant for license shall possess one of the following qualifications in order to take the examination(s):

1. general pest control, commercial vertebrate control and fumigation:

a. a degree from an accredited four-year college or university with a major in entomology; or

b. a degree from an accredited four-year college or university with at least 12 semester hours or the equivalent in quarter hours of course work in entomology and at least one year of experience as a registered technician under the supervision of a licensee in the licensee phase for which the applicant desires to take the examination; or

c. four years of experience as a registered technician under the supervision of a licensee in the licensee phase for which the applicant desires to take the examination; or

d. four years of experience as a technician under the supervision of a structural pest control operator in another state in the licensee phase for which the individual desires to take the examinations. Experience with an out-of-state structural pest control operator shall be substantiated by evidence acceptable to the commission;

2. termite control:

a. a degree from an accredited four-year college or university with a major in entomology and complete a commission approved comprehensive termite program; or

b. a degree from an accredited four-year college or university with at least 12 semester hours or the equivalent in quarter hours of course work in entomology and at least one year of experience as a registered technician under the supervision of a licensee in the licensee phase for which the applicant desires to take the examination and complete a commission approved comprehensive termite program; or

c. four years of experience as a registered technician under the supervision of a licensee in the licensee phase for which the applicant desires to take the examination

and complete a commission approved comprehensive termite program; or

d. four years of experience as a technician under the supervision of a structural pest control operator in another state in the licensee phase for which the individual desires to take the examinations and complete a commission approved comprehensive termite program. Experience with an out-of-state structural pest control operator shall be substantiated by evidence acceptable to the commission.

C. Each applicant for a ship fumigation license shall possess one of the following qualifications in order to take the examination:

1. a degree from an accredited four-year college or university with a major in entomology and 200 jobs in ship fumigation working under the supervision of a licensed ship fumigator; or

2. a degree from an accredited four-year college or university with at least 12 semester hours or the equivalent in quarter hours of course work in entomology and at least one year of experience as a registered technician under the supervision of a licensee in ship fumigation; or

3. four years of experience as a registered technician under the supervision of a licensee in ship fumigation; or

4. experience as a certified ship fumigation technician having completed 200 jobs in ship fumigation working under the supervision of a licensed ship fumigator; or

5. four years of experience as a technician under the supervision of a structural pest control operator in another state in ship fumigation. Experience with an out-of-state structural pest control operator shall be substantiated by evidence acceptable to the commission; or

6. 200 jobs in ship fumigation that the applicant has worked as a registered technician in ship fumigation working under the supervision of a licensed ship fumigator, during a two-year period.

D. Each applicant for licensure shall also demonstrate the following competencies:

1. knowledge of the practical and scientific facts underlying the practice of structural pest control, control of wood-destroying insects and/or fumigation; and

2. knowledge and ability to recognize and control hazardous conditions which might affect human life or health.

E. Each applicant shall successfully complete the appropriate examination for certification prior to issuance of the structural pest control license.

F. In addition to the qualifications required by §107.B-C, each applicant for licensure ~~must~~ shall:

1. submit a complete application for examination as required by §109 hereof;

2. be approved by the commission to take the examination for licensure;

3. have successfully completed a written examination for licensure no more than two years prior to the date of issuance of the license;

G. Out-of-state applicants for licensure shall meet the educational requirements shown in Paragraph B.1 or produce evidence satisfactory to the commission of four years of experience under the supervision of a recognized and reputable pest control operator. Experience in pest control work in another state will be verified with the appropriate regulatory agency of the other state before out-

of-state applicant will be allowed to take the examination for licensure in Louisiana.

H. The commission shall consider each application for examination for licensure in open session. The commission may verify the contents of any application prior to taking final action to approve/disapprove the applicant to take the examination. The commission may disapprove an applicant, or defer action on the application to take the examination, in any instance when the contents of the application cannot be verified. Action to grant/deny approval for the applicant to take the examination shall be taken only upon the affirmative vote of three members of the commission. No license shall be issued until the commission has approved the application.

I. All applicants who are approved by the commission will, upon successfully completing the examination for licensure as set forth in §109 hereof, receive a single license to engage in structural pest control work, which license shall specify on the face thereof the specific phase or phases of structural pest control work for which the license is issued, as follows:

1. general pest control;
2. commercial vertebrate control;
3. termite control;
4. structural fumigation;
5. ship fumigation;
6. commodity fumigation.

J. A license to engage in structural pest control work is permanent unless suspended or revoked by the commission as provided in §131.

K. A licensee shall perform or supervise structural pest control work only in the phase or phases of the license for which he is licensed by the commission.

L. Each license is personal to the holder and shall not be transferred to another for any purpose or for any period of time and may not be utilized in any way by any person other than the licensee whose name appears on the face of the license.

M. All licenses shall be displayed at the place of business at all times.

N. The commission may deny a license to any person proven to have committed any of the violations set forth in §127 hereof.

O. A licensee approved in one phase of pest control work may be licensed in additional phases by successfully completing the examination for the additional phase. However, the license for additional phase or phases of structural pest control work shall not be issued until the commission approves the licensee to take the examination for the additional phase or phases.

P. Any permittee\licensee desiring to utilize a telephone answering service other than at locations holding a place of business permit shall submit a written department.

Q. A licensee shall only have one license with all phases for which he possesses issued at one place of business.

R. When a license phase has not been recertified, the licensee shall comply with all requirements for initial licensing contained in §107 and §109 or in a written request to the department to retest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3368.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:326 (April

1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:955 (November 1989), LR 19:1009 (August 1993), LR 23:855 (July 1997), LR 23:1493 (November 1997), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 31:2761 (November 2005), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 32:796 (May 2006), repromulgated LR 32:1016 (June 2006), amended, LR 37:276 (January 2011).

**§109. Application for Examination; Contents of Application**

A. An application for examination for licensure may be made at any time by filing a complete application, on forms provided by the commission.

B. A complete application for examination shall be filed in the commission office at least 30 working days prior to any scheduled meeting of the commission to be routinely placed on the agenda for consideration by the commission.

C. Each applicant for examination shall pay a nonrefundable fee of \$50 per examination upon the commission's approval of the applicant's application for examination.

D. Each application for examination shall contain the following information:

1. business name, address and phone number of the business domicile of the applicant;

2. name and residence address of the applicant;

3. educational qualifications. For applicants seeking licensure on the basis of educational qualifications, a certified copy of the applicant's college or university transcript shall be provided;

4. proof of practical experience in pest control work:

a. upon request of the commission, the applicant shall submit from the said supervising licensee, a written statement that the jobs have been participated in by the applicant under his supervision and that the applicant has demonstrated the requisite knowledge to perform and supervise such work;

b. experience in pest control work. Information to be provided includes, but is not limited to, business name and address where employed under supervision, name of the licensee providing supervision to the applicant and evidence of registration while in the claimed employment. Applicants seeking licensure on the basis of experience shall provide a notarized statement from the licensee who supervised the applicant, attesting to the period of supervised employment and the capacity in which the applicant was employed, said affidavit to be executed on a form to be provided by the department;

c. if at the time of application, the licensee who provided supervision is deceased, his whereabouts are unknown, or fails or refuses to supply the statement, affidavit, or both, required under Subparagraphs a and b above, then the commission may waive the requirements for such statement, affidavit, or both upon:

i. submission by the applicant of a notarized statement signed by the applicant that the licensee who provided supervision is deceased, his whereabouts are unknown, or fails or refuses to supply the statement, affidavit, or both, required under Subparagraphs a and b above, and

ii. verification by the department to the commission of the applicant's experience in pest control work.

E. Any applicant who is not approved by the commission to take the examination will be notified of the commission's decision. An applicant who has not been approved by the commission to take an examination will not be admitted to the examination.

F. Copies of applications for examinations may be provided to the commission members for informational purposes during the interim between commission meetings.

G. Examinations will be given once during each quarter of the year by the director or the secretary only at the times or places which have been previously announced for each quarter.

H. The written examination shall be supplemented by oral examination and/or visual identification of specific pests and insects.

I. The minimum score required for successful completion of the examination is 70 percent.

J. An applicant shall be disqualified from completing an examination or taking any other examination administered under these rules and regulations if the applicant is caught or found to be cheating on an examination or using any written materials, electronic devices, or other means during an examination, which have not been authorized or allowed by the director or person administering the examination.

1. Any such applicant shall not be allowed to finish the examination and shall receive a score of zero. If an applicant finished the examination prior to the discovery of the cheating or use of unauthorized written materials, electronic devices, or other means the applicant's examination shall be voided and the applicant shall receive a score of zero.

2. Any applicant who is not allowed under this Subsection J to finish an examination, or whose examination is voided, or who is disqualified from taking the examination or any other examination administered under these rules and regulations may appeal the action to the commission.

i. The appeal shall be in writing, state the grounds for the appeal, and filed with the director or secretary within 30 days of the date of the action complained of.

ii. The appeal will be placed on the agenda for the next meeting of the commission and the applicant will be notified of the date and place of the next meeting.

iii. The appeal will be decided by the commission. The decision of the commission shall be the final administrative decision in the matter.

iv. An appeal from the decision of the commission shall be in accordance with the Administrative Procedure Act.

v. The action or administrative decision shall become final if no appeal is timely filed at any step in the proceedings or if the action is upheld on appeal.

3. During the pendency of any appeal or during the time limit for the filing of any appeal the applicant shall not be allowed to take any examination administered under these rules and regulations.

4. If the action or administrative decision is not appealed or is upheld on appeal then the applicant shall not be allowed to take or re-take the examination or any other

examination administered under these rules and regulations for a period of three years from the examination date without the approval of the commission given at a meeting of the commission.

K. Each applicant shall be sent written notification of his or her examination results within 30 days after completing of the examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3368.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:326 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:955 (November 1989), LR 35:206 (February 2009), LR 37:278 (January 2011).

### **§111. Certified Fumigation Technician**

A. A mandatory two-year registered technician in the fumigation phase under a licensed fumigator, as is required. After the two years, the licensed fumigator would have to submit a list of the following:

1. six jobs in structural fumigation that this particular applicant has worked from start to finish;

2. six jobs in commodity fumigation that this particular applicant has worked from start to finish;

B. Having met these requirements in §111.A, the applicant would be qualified to take a written test administered by the commission to demonstrate that the person has the necessary knowledge in the category or categories for which application is made. The minimum score required for successful completion of the examination is 70 percent.

C. The certified fumigation technician shall maintain his registration in current status by:

1. attending a continuing education program at least once every three years;

2. the continuing education program shall contain a minimum of six hours of technical training for the category of fumigation;

3. shall attend the entire approved continued education program for technicians, otherwise the certified fumigation technician would not maintain his registration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3369.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, amended LR 17:251 (March 1991), LR 19:1010 (August 1993), LR 37:279 (January 2011).

### **§113. Registration of Employees; Duties of Licensee and Registered Employee with Respect to Registration**

A. The permittee shall register, on a form to be provided by the commission, every employee under the supervision of a licensee with the commission within 30 days after the commencement of the employee's employment and shall test as required by R.S. 3:3369.H.

B. The registration application of each employee shall contain the following information:

1. name and address of the business location where the employee is domiciled;

2. name, address and phone number of the licensee providing supervision over the employee;

3. name and residence address of the employee to be registered;

4. phase(s) of pest control work in which the employee will work and be supervised;

5. date of employment of the employee;

6. one (2 inches by 2 inches) photographs of the employee; and

7. date of birth.

C. The fees for the registration of technician shall be as follows.

1. The fee of the administrative processing of the registration certificate shall be \$20. This fee shall be paid at the time of initial registration.

2. The administrative processing of change of registration each time a registered technician is employed by a different pest control operator shall be \$10.

3. The fee for the examination for the technician registration shall be \$25.

D. An employee's registration certificate shall be issued within 20 working days after the department receives the completed registration form or the technician has successfully passed the examination, whichever is later.

E. The requirements for the examination are as follows.

1. Each employee requesting to take the examination will be notified by the department of the date, time, and location of the next available examination.

2. The minimum score required for successful completion of the examination is 70 percent.

3. The consequences and procedures that apply as a result of cheating on an examination or using any written materials, electronic devices, or other means during an examination, which have not been authorized or allowed by the director or person administering the examination are the same as are provided for in §109.J of this Chapter.

4. Each employee who did not successfully pass the examination will be notified of the results in writing within twenty working days after the examination.

F. Each registration certificate is personal to the holder and shall not be transferred to another for any purpose or for any period of time and shall not be utilized in any way by any person other than the registered employee whose name appears on the certificate.

G. A registration certificate is valid only while the registered employee remains under the supervision of a licensee at this place of business.

H. The permittee\licensee shall require the registered employee to sign the registration certificate, in his presence, within five days after the permittee\licensee receives the registration certificate.

I. A registered employee shall have his registration certificate in his possession at all times while engaging in pest control work and shall display his registration certificate upon reasonable request by any employee of the department and to any person for whom pest control work is being performed.

J. A registered employee shall perform pest control work only in the phase of pest control work for which he is registered.

K. Upon termination of a registered employee, the licensee shall secure the employee's registration certificate, notify the department of the employee's termination and return the registration certificate to the department within five working days after the termination.

L. If the licensee is unable to retrieve the registration certificate of a terminated employee, the licensee shall notify the department of the employee's termination within five working days after the termination and provide written reasons for the failure to retrieve the terminated employee's registration certificate.

M. Each employee and/or registered technician shall remit to each employer all funds collected in connection with structural pest control work performed by the employee within 10 calendar days.

N. Each employer shall pay each employee and/or registered technician in accordance with the terms of the employment agreement between them.

O. Each employer shall keep complete records at the place of business establishment of all structural pest control work performed for a period of at least two years. These records shall include the address of the structure treated, the name of the technician who performed the treatment, the name of the person for whom the treatment was performed, and the common name of the pesticide applied.

P. Each registered technician shall participate in an entire continuing education program as a condition of maintaining his or her status as a registered technician at least once annually (July 1 to June 30).

1. Each continuing education program, minimum of four hours of technical training, shall be approved in advance by the department.

2. Each continuing education program shall be a minimum of one hour in length per category.

3. Documentation of the technician attendance and participation shall be forwarded to the department and a copy retained at the technician's place of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366, 3:3368 and R.S. 3:3369.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:327 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:956 (November 1989), LR 32:797 (May 2006), repromulgated LR 32:1016 (June 2006), amended LR 35:207 (February 2009), LR 37:279 (January 2011).

### **§115. Certified WDIR Technician**

A. Requirements of a Certified WDIR technician, prior to conducting WDIR inspections, are as follows:

1. shall be registered as a termite technician; and

2. complete department approved WDIR training; and

3. pass WDIR technician test with a score of 70 or greater; and

4. pay the fee for the examination for the WDIR technician registration which shall be \$25; and

5. complete application form provided by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3369.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 23:855 (July 1997), amended LR 32:797 (May 2006), repromulgated LR 32:1016 (June 2006), amended LR 37:280 (January 2011).

### **§117. Obligations of the Licensee\Permittee**

A. The permittee or the primary licensee shall keep the bond and general liability insurance required under §107.F in full force and effect at all times.

B. The permittee or the primary licensee shall renew the permit for operation for each business location annually prior to June 30.

C. The permittee or the primary licensee shall apply for a registration certificate for each employee under his supervision within 30 days after the employee is hired and shall comply with all other requirements pertaining to registration of employees set forth in §113.

D. The primary licensee shall be responsible for training the employee in the kind of work which he will perform.

E. Maintenance of a commercial applicator certification by a licensee

1. A licensee shall maintain his commercial applicator certification in current status by:

a. attending a continuing educational program for recertification approved by the department;

b. recertification at least once every three years; such recertification shall be completed by December 31 of the year preceding the third anniversary of either the original certification or the most recent recertification;

c. a minimum of six hours of technical training which shall include but not limited to the phases of general pest control, termite control and commercial vertebrate control;

d. a minimum of six hours of technical training for the category of fumigation.

2. A licensee attending an approved recertification seminar shall attend the entire approved program; otherwise the licensee shall not be recertified at this approved seminar.

3. Time and location for each licensee recertification can be obtained by calling or writing to the department.

F. A licensee shall be available to provide direct supervision over all employees registered under his license on a regular, ongoing basis.

G. The permittee or the primary licensee shall report all termite contracts and all wood-destroying insect reports and pay all required fees as set forth in §119 hereof.

H. Any person applying pesticides for a fee and the permittee or the primary licensee shall maintain records according to LAC 7:XXV.117.I, at the physical address listed on the place of business permit of all applications of pesticides on a record keeping form or in a format approved by the director of Pesticide and Environmental Programs of the department. These records shall be retained for a period of two years after the date of the pesticide application for ship and commodity fumigation, general pest control and commercial vertebrate control and a period of two years after the expiration of applicable contracts for termite and other wood destroying insect control. The licensee shall make a copy of these records available to any employee of the department for inspection at a reasonable time during normal working hours.

1. Records for applications of pesticides for wood destroying insects shall contain the following information:

a. place of business name, address, and number;

b. primary licensee name, address, and department

I.D. number;

c. customer name and address;

d. location of application;

e. product\brand name;

- f. EPA registration number;
  - g. restricted\general use pesticide;
  - h. application date and time;
  - i. target pest;
  - j. type of application (pre-treat, post, spot, etc.);
  - k. size of area treated (square feet or linear feet);
  - l. mixture concentration;
  - m. total amount of product mixture applied;
  - n. applicator and department I.D. number.
2. Record keeping for applications of pesticides in the general pest and commercial vertebrate phases shall contain the following information:
- a. place of business name address, and number;
  - b. primary licensee name, address, and certification department I.D. number;
  - c. customer name and address;
  - d. location of application;
  - e. product/brand name;
  - f. EPA registration number;
  - g. restricted/general use pesticide;
  - h. application date and time;
  - i. pest treated/type of application;
  - j. mixture concentration (percent);
  - k. applicator and department I.D. number.
3. Records for applications of pesticides in the fumigation phase shall contain the following information:
- a. place of business name, address, and number;
  - b. primary licensee name, address, and department I.D. number;
  - c. customer name and address;
  - d. location of application;
  - e. product/brand name;
  - f. EPA registration number;
  - g. restricted/general use pesticide;
  - h. application date and time;
  - i. pest treated;
  - j. type of application (ship, structure, commodity);
  - k. size of area treated (cubic feet);
  - l. rate applied;
  - m. total amount of product applied;
  - n. applicator, department I.D. number.
4. Records for using bait and baiting systems shall contain the following information:
- a. place of business name, address, and phone number;
  - b. primary licensee name, address, and department I.D. number;
  - c. customer name and address;
  - d. physical address of contracted structure;
  - e. product/brand name;
  - f. EPA registration number;
  - g. restricted\general use pesticide;
  - h. linear feet of perimeter of the treated structure(s);
  - i. date each monitoring stations installed or inspected;
  - j. date each ground bait station installed, inspected or replaced;
  - k. date each above ground bait station installed, inspected or replaced;
  - l. number of monitoring, ground and above ground bait stations inspected during each inspection;

- m. name and certification\registration number of person inspecting;
  - n. inspection diagram.
- I. The licensee shall renew each category in which he is licensed annually by June 30.
- J. The annual fee for licensed pest control operators shall be \$5 for each category in which the pest control operator is licensed.
- K. The permittee or the primary licensee shall report to the department all termite contracts, termite perimeter applications and wood destroying insect reports completed each month on the form provided by the department. The reports listed above are due in Division of Pesticide and Environmental Programs office in Baton Rouge on or before the tenth of the month following the contract or application or report.
- L. The fee for each standard contract and wood-destroying insect report that has been issued is \$8. All such fees are due and payable to the department at the time the reports required by §119.E are due.
- M. The permittee or the primary licensee shall have provisions for spill control including materials and tools on every vehicle transporting pesticides.
- N. Signage of Vehicles
1. General. A motor vehicle being operated by a place of business that is engaged in the transport or application of pesticides shall be marked as specified below:
- a. magnetic or removable signs may be used;
  - b. size, shape, location and color of marking. The marking shall contain the following:
    - i. appear on both sides of the vehicle;
    - ii. be in letters that contrast sharply in color with the background;
    - iii. be readily legible during daylight hours;
    - iv. lettering shall be a minimum of 2 inches in height;
    - v. be kept and maintained in a manner that retains the legibility of the information required by §117.O.1.c;
  - c. nature of marking. The marking shall display the following information:
    - i. the name or trade name of the place of business operating the vehicle.
- O. No employee shall use a telephone number, advertise or solicit business unless approved, in writing, by the permittee or licensee and reported in writing to the department.
- P. The pest control operator shall record the nature of the completion and the date of completion that construction of a structure is completed, as found in §101.B within the definition of *construction*, and maintain the date as part of the application records.
- AUTHORITY NOTE: Promulgated in accordance with R.S. R.S. 3:3366 and 3:3368.
- HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:327 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:956 (November 1989), LR 21:930 (September 1995), LR 23:855 (July 1997), LR 26:2437 (November 2000), LR 29:1062 (July 2003), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 30:196 (February 2004), LR 31:2761 (November 2005), LR 35:1468 (August 2009), LR 37:280 (January 2011).

### **§119. Contracts for Termite Control Work**

A. The permittee or a licensee shall enter into a written contract for termite work with the property owner/agent employing him. The contract shall:

1. be in a form provided or approved by the commission;
2. guarantee performance for a period of not less than 1 year after the treatment is made;
3. guarantee treatment of the structure(s) in accordance with minimum specifications for termite control work set forth in §141 hereof;
4. provide for at least one inspection of all unobstructed or accessible areas outside of the structure(s) prior to expiration of the agreement;
5. include an inspection diagram;
6. provide for the treatment of all subterranean termites; and
7. include a damage repair warranty and be exclusive to the property owner for 5 years subject to the terms and conditions of the contract, if the contract is for pre construction or new construction termiticide treatment.

B. Each contract for termite control work shall cover only one unit or one individual property, provided that the contract may include a garage appurtenant to the unit or individual property.

C. Contracts for spot termite treatments shall guarantee the area treated for a period of one year.

D. The permittee or a licensee shall report to the commission, no later than the tenth day of each month, each termite contract and initial treatment for a pre-treatment contract for termite work which he has entered into, and performed or completed during the previous month. If no contracts were entered into or performed during the previous month, the permittee or a licensee shall report this fact to the commission no later than the tenth of each month.

E. A licensee or permittee shall pay to the department the required fee for each standard contract issued when the required monthly report is filed with the department.

F. Termite treatment contracts that include termite monitoring stations shall include a contract addendum that provides the number of monitoring station(s) and the frequency of inspection(s). The contract addendum shall be approved by the commission prior to its use.

G. A licensee or any technician working under the licensee's supervision shall enter into a written agreement for monitoring for subterranean termites with the structure owner/agent employing him/her, which agreement shall:

1. be in a form approved by the commission;
2. provide for the frequency of inspections that shall include at least one inspection of the structure prior to expiration of the agreement;
3. provide for the number of subterranean termite monitoring station(s);
4. provide for the owner name, address, city, state, zip code of the structure;
5. provide the name, address, city, state, zip code of the pest control company.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and R.S. 3:3370.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:328 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:957 (November 1989),

LR 26:2437 (November 2000), LR 27:1179 (August 2001), LR 27:2084 (December 2001), LR 28:1171 (June 2002), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 30:196 (February 2004), LR 30:1144 (June 2004), amended by the Department of Agriculture and Forestry, Office of Agriculture and Environmental Sciences, LR 31:26 (January 2005), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 35:1468 (August 2009), LR 37:282 (January 2011).

### **§121. Wood Destroying Insect Report**

A. A wood destroying insect report approved by the commission shall be issued when any inspection is made to determine the presence of wood destroying insects, specifically for acts of sale of structures, but not limited for this purpose.

B. Any wood destroying insect report or written instrument issued for the transfer of real property shall be issued by a person who is licensed by the commission in termite control or a certified WDIR technician, and is working under the supervision of a person who is licensed by the commission in termite control. This instrument shall carry a guarantee that the property will be treated without charge should live wood destroying insects with the exception, the presence of frass will be acceptable as evidence of a live infestation of powder post beetles; however, frass shall be exuding or streaming from the holes on the outside of the wood, covered by this report, and be found within 90 days from date of inspection.

1. A contract approved by the commission shall be issued on date of treatment.

2. This contract shall be reported to the commission and a fee paid as required by the Structural Pest Control Law.

C. Regulations for completing wood destroying insect reports LPCA-143 WDIR without the Arbitration clause and 143 A. with the Arbitration clause. The following numbered sections correspond to the numbered sections on WDIR Form LPCA 143 and 143 A. LPCA 143 and 143 A shall be completed as follows.

1. Enter HUD/FHA/VA Case number (if available).
2. Enter date of structure(s) inspection.
- 3.A. Enter name of inspection company.
- 3.B. Enter address (including street, city, state, and zip code) of inspection company.
- 3.C. Enter telephone number (include area code) of inspection company.
4. Enter pest control inspector license number.
- 5.A. Enter name and address of property owner/seller at the time of inspection.
- 5.B. Enter address of property inspected (including street, city, state, and zip code).
- 5.C. List only structures located at address in 5B that are part of this report.
- 5.D. Information only. This area shall not be checked, circled or marked in any way.
6. If any areas of the structure(s) were obstructed or inaccessible mark box YES. If no, mark box NO.
7. Check the appropriate block as to the construction of the structure(s) inspected. More than one block can be checked.
- 8.A. Check this block only when there is no visible evidence of wood destroying insects in accessible areas on the structure(s) inspected. Evidence includes but is not limited to: live or dead wood destroying insects, wood destroying insect parts, shelter tubes, shelter tube stains, frass, exit holes or damaged wood due to wood destroying insects.
- 8.B. Check this block if evidence of wood destroying insects is observed. Evidence includes but is not limited to: live or dead wood destroying insects, wood destroying insect parts, shelter

tubes, shelter tube stains, frass, exit holes or evidence of damage due to wood destroying insects. If live wood destroying insects are observed, identify and list the insect(s) observed and the location(s) in this Section.

8.C. Check this box if visible evidence of damage due to wood destroying insects was observed. Evidence of damage is defined as obvious feeding or removal of wood by wood destroying insects including "etching" or "scabbing" marks on the wood surface(s). Identify the wood destroying insect and list the location(s) of evidence of damage caused by wood destroying insects in this Section.

8.D. Treatment was or will be performed by inspection company? YES or No; If YES, explain as follows:

a. Inspecting company with a current treatment contract on the structure(s) inspected: list the original treatment date for all structures treated and the contract type.

b. Inspecting company without a current treatment contract on the structure(s) inspected: list the structure(s) to be treated and the type of treatment and contract.

9. Additional comments (If necessary, continue on reverse side).

10. Make no marks in this section.

11. Do not mark in this section.

a. If any of the conditions listed in this paragraph on the WDIR (LPCA 143 & 143 A) are present under or to within 12 inches of the inspected structure(s), list them in section #10 of this report.

12. Signature and registration/licensee number of inspector conducting the inspection.

13. Enter date of inspector signature.

14. Enter name of person requesting the WDIR (if available).

15. Enter name of person WDIR received by (if available).

16. Title of person in Number 15 (if available).

17. Date of signature of Number 15 (if available).

#### D. Minimum Specifications for conducting a Wood Destroying Insect Report

1. No person shall conduct a WDIR inspection unless that person is properly licensed in termite control or is a certified WDIR technician.

2. Persons described in LAC 7:XXIII.121.D.1 shall inspect all unobstructed or accessible areas including but not limited to bath traps with visible access, crawl spaces of raised pier construction, and attics having a permanent ladder or staircase specifically to provide access to the attic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and R.S. 3:3670.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 23:856 (July 1997), LR 24:631 (April 1998), LR 25:235 (February 1999), LR 25:829 (May 1999), amended by the Department of Agriculture and Forestry, Office of Agriculture and Environmental Sciences, LR 31:26 (January 2005), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 32:797 (May 2006), repromulgated LR 32:1017 (June 2006), amended, LR 37:282 (January 2011).

#### §123. Change in Status of Licensee

A. Any change in a licensee's status (e.g., death, retirement, prolonged illness, merger of companies, sale, change of ownership, etc.) shall be reported to the commission, in writing, within 14 days after the change in status occurs by the permittee or primary licensee.

B. When any change in status occurs, provisions shall be made for supervision at any location where there is no licensee during the interim until another licensee is approved by the commission for examination. The person in charge of the permitted location where the change in status occurred shall notify the department, in writing, of the name and

address of the licensee providing supervision during the interim within 14 days after the change occurs. Supervising licensee shall notify the department of his acceptance of this supervision within 14 days of his acceptance.

C. When the change in status results in no licensee being domiciled at a permitted location, an applicant who is eligible for licensure shall be approved by the commission for examination either:

1. at the next meeting of the commission after the change in status occurs; or

2. within 90 days after the change in status occurs, whichever is later. During this period no use of restricted-use pesticides is permitted.

D. When the change of status is within the same company, there is no grace period.

E. When the death or disability of a licensee occurs, resulting in no licensee being domiciled at the permitted location, the commission may extend the period for qualifying a new licensee for an additional 90 days before revoking or canceling the permit for operation.

F. During the temporary absence of the licensee, the permittee/licensee shall designate another licensee(s), certified in the same categories as the licensee, to perform the duties that require the physical presence of a licensee for a period of time not to exceed 30 days. For the purpose of this Chapter, temporary absence shall mean any absence where the licensee would reasonably be expected to return to his duties. The licensee shall notify the department in writing of any such temporary absence giving the name of the substituting licensee jointly responsible with the licensee, and the dates of the temporary absence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3368.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:328 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:957 (November 1989), LR 37:283 (January 2011).

#### §125. Inactive Status of License

A. Upon written notice to the commission, any licensee may place his license on inactive status during any period of time when he will not be directly engaged in pest control work.

B. Notice to the commission shall include the period for which inactive status is requested and any information which may support the licensee's request for placement of his license on inactive status.

C. The license of any licensee which has been placed on inactive status shall be maintained in current status as provided in §117.F.

D. The commission may deny or defer action on a request to return a license to active status, regardless of the period of time when the license has been on inactive status, whenever the licensee on inactive status has been proven guilty in an adjudicatory proceeding of any of the violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S. 3:3366 and 3:3368.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:328 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:957 (November 1989), LR 37:283 (January 2011).

**§127. Adjudicatory Proceedings of the Commission; Violations**

A. The commission may place a licensee/registered employee on probationary status or suspend/revoke a license/registration certificate by holding an adjudicatory proceeding noticed and conducted in accordance with the requirements of the Administrative Procedure Act and the Structural Pest Control Law.

B. Whenever the commission has reason to believe that a licensee/registered employee has violated any provision of the Act or these rules and regulations, the commission shall notify the licensee/registered employee, by certified mail, at least 30 days prior to the scheduled hearing date.

C. In addition to providing all information required by the Administrative Procedure Act, the notice required in §125.B shall state that failure to appear at the scheduled hearing may result in the suspension or revocation of the license/registration certificate.

D. The commission may place a licensee/registered employee on probationary status or suspend/revoke his license/registration certificate when any of the following violations are sustained in a properly noticed adjudicatory proceeding:

1. misrepresentation for the purpose of defrauding;
2. deceiving or defrauding;
3. knowingly making false statements;
4. failure by a licensee to provide true and correct information to the commission;
5. failure to comply with any of the requirements of the Act or these rules and regulations;
6. failure to pay required fees;
7. intentional misrepresentation in an application for license and/or employee registration;
8. conviction in any court of law violations of the Act or of any felony;
9. knowingly permitting any person under the supervision of the offender to violate any provisions of the Act or these rules and regulations;
10. failure to enter into a written contract with the property owner employing the pest control operator for termite work;
11. failure to comply with the minimum specifications for termite control work set forth in §141;
12. failure to follow the label and labeling requirement in the application of any pesticide not specifically covered in §141;
13. failure to maintain required insurance coverages and fidelity or surety bonds in full force and effect;
14. failure to fulfill the terms of any written guarantees or agreements entered into;
15. failure to attend an approved training program for commercial applicator certification during any three-year period and failure to maintain current status as a commercial applicator;
16. knowingly making any false or misleading statement in a wood-destroying report;
17. gross negligence in conducting an inspection or failing to make an inspection prior to issuance of a wood-infestation report; or
18. conviction of a violation or assessment of a civil penalty under FIFRA or Louisiana Pesticide Law;

19. failure of a registered technician to attend an approved training program during any one-year period;

20. failure to maintain proper signage on vehicles or;

21. failure to keep records on all pesticide applications as required by §117.I;

22. operating faulty or unsafe equipment;

23. operating in a faulty, careless, or negligent manner.

24. The intentional misrepresentation is the misrepresentation or suppression of a substantial fact with the intent either to obtain an unjust advantage for any person or to cause a loss or inconvenience to any person. Intentional misrepresentation may occur through words or actions, or by silence or inaction. The following acts are illustrative of intentional misrepresentation:

1. Failure of a registered technician to report structural pest control work performed by him or to remit any fees for structural pest control work collected by him, to his employer within 10 calendar days after performing the work or collecting the fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3672.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:328 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:957 (November 1989), LR 23:854 (July 1997), LR 37:284 (January 2011).

**§129. Probationary Status of Licensee/Registered Employee**

A. A license or registration certification may be placed on probationary status only upon the affirmative vote of three members of the commission at an adjudicatory proceeding noticed and conducted as required under §127.

B. When a minor violation is sustained before the commission in an adjudicatory proceeding, a licensee or registered employee may be placed on probation for a period not to exceed six months.

C. When a moderate violation is sustained before the commission in an adjudicatory proceeding, the licensee or registered employee may be placed on probation for a period not to exceed one year.

D. When multiple violations (i.e., violations of more than one provision of the Act or these rules and regulations or more than one violation of the same provision of law or regulations) are sustained before the commission, the commission shall consider each separate violation and take appropriate action with respect thereto.

E. Whenever any licensee or registered employee is found in an adjudicatory proceeding to have committed a major violation or multiple violations of the Act or these rules and regulations, the commission may suspend or revoke the license/registration certificate without first imposing a period of probation.

F. Any violation of the Act or these rules and regulations during a period of probationary status will subject the offender to more severe penalties, including suspension and/or revocation of his license or registration certificate and/or the initiation of proceedings in a court of competent jurisdiction.

G. If the violations resulting in the imposition of probationary status are corrected during the period of probationary status, the probationary period shall

automatically expire, without notice, at the end of the probationary period specified by the commission.

H. If the violations resulting in the imposition of the probationary status are not corrected during such period of probationary status, the commission may either:

1. renew the period of probationary status; or
2. suspend/revoke the license/registration certificate after an adjudicatory hearing noticed and conducted under §127.

I. The licensee/registered employee may continue to work during any period of probationary status.

J. The commission may place a licensee/registered employee on probationary status for one phase of pest control work for which he is licensed/registered without effect upon any other phase of pest control work for which he is licensed/registered.

K. The commission may place on probation all phases of pest control work for which the licensee/employee is licensed/registered for a violation occurring in only one phase of pest control work.

L. The commission shall notify the licensee/registered employee, in writing, of:

1. the nature of the violations sustained before the commission, including dates and places where the violations occurred;
2. the period of probationary status;
3. the phases of the license/registration certificate affected by the probationary status; and
4. any additional terms and conditions imposed by the commission.

M. A licensee/registered employee may be placed on probationary status for a cumulative total of no more than 24 months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3370.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:329 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:284 (January 2011).

### **§131. Suspension/Revocation of License/Registration**

A. A license/registration may be suspended/revoked by the commission:

1. only upon the unanimous vote of the commission; and
2. only for a violation of the Act or these rules and regulations sustained before the commission in an adjudicatory proceeding noticed and conducted as required under §127 hereof.

B. The commission may suspend/revoke a license/registration for any major violation without previously imposing a period of probationary status.

C. Any suspension of a license/registration shall be for a specific period of time, and the licensee/registered employee shall be notified in writing of the period of time and any conditions which may be imposed on the reinstatement thereof.

D. In addition to the period of suspension, the commission may impose additional terms and conditions which shall be met before the license/registration will be reinstated.

E. The licensee/registered employee shall not perform any work in any phase of pest control work, including in the case of licensees the supervision of registered employees,

when his license/registration for that phase of pest control work has been suspended by the commission.

F. The commission may suspend the license/registration for one phase of pest control work without effect upon any other phase of pest control work for which the licensee/employee is licensed/registered.

G. The commission may suspend all phases of pest control work for which the licensee/employee is licensed/registered for a major violation occurring in only one phase of pest control work.

H. Upon provision of evidence acceptable to the commission, either before or at the expiration date for the period of suspension, that the violations which resulted in the suspension have been corrected, the suspension may be terminated by the commission.

I. When a license/registration certificate has been revoked by the commission, the license/registration certificate may not be reinstated until such time as the former licensee meets all requirements set forth in §§105, 107, 109 hereof and/or the former registered employee meets all requirements set forth in §113 hereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3370.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:329 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:285 (January 2011).

### **§133. Inspection, Taking of Samples**

A. During the course of their inspections, inspectors employed by the commission may take soil samples and/or chemical samples of tank mixes and/or rodenticide.

B. Soil and chemical samples shall be properly marked to preserve a chain of custody record and shall be submitted to the laboratory at Louisiana State University for analysis.

C. Results of laboratory analysis of soil and/or chemical samples may be used in adjudicatory proceedings and shall be made available to the pest control operator upon request after the analysis is completed.

D. Samples that are requested by any other person other than for enforcement by the department shall be paid for by the person requesting the chemical sample. The fee shall be \$500 per sample which includes one (1) analysis and the cost for obtaining the samples by the employee of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:958 (November 1989), LR 37:285 (January 2011).

### **§135. Prohibitions**

A. A pest control operator shall not engage in any phase of structural pest control work for which he is not specifically licensed by the commission.

B. No person engaged in the sale of products for the eradication of household pests or wood-destroying insects shall demonstrate such products by applying the products to the premises of a customer without first obtaining a license from the commission.

C. No examination for licensure will be given if the applicant is not eligible for licensure on the basis of education and/or experience.

D. No person shall assign a registered licensee\employee to perform structural pest control work in any phase for which he is not licensed or registered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and 3:3371.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:285 (January 2011).

### §137. Exceptions

A. These rules and regulations do not apply to the application of pesticides for the control of agricultural pests.

B. These rules and regulations do not apply to any person, firm, partnership, corporation, association or other organization or combination thereof engaged in the manufacturing or selling of products to the general public for the control of household pests and termites, provided that such entities shall not apply such products, by way of demonstration or otherwise, to a customer's premises or offer any services connected with pest control unless licensed to do so by the commission.

C. These rules and regulations do not apply to persons who personally apply pesticides of any kind for the control of household pests or wood-destroying insects on property which they own, rent or lease.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366 and R.S. 3:3376.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:286 (January 2011).

### §139. Complaints against Pest Control Operators

A. Any citizen may file a complaint in writing against any pest control operator by contacting the commission's office.

B. Upon receipt of a written complaint, the commission staff shall:

1. conduct an investigation of the incident involved in the complaint; and

2. inform the pest control operator against whom the complaint has been lodged.

C. Upon completion of the investigation required under §139.B, the commission staff shall notify the complainant and the pest control operator of the results of its investigation when requested in writing.

D. The department may bring any matter arising from a citizen's complaint to an adjudicatory hearing if, in the judgment of the department, the facts established in the investigation required under §139.B warrant such action.

E. In any instance where a citizen feels that the facts of his complaint warrant an adjudicatory hearing by the commission, the citizen may request, in writing, that the matter be placed on the agenda for consideration at the next meeting of the commission, provided that the citizen shall appear and give sworn testimony at such hearing called at the request of the citizen. In any instance where a citizen has filed a written petition for an adjudicatory proceeding but fails to appear, upon proper notice, and give testimony, the commission may cancel such adjudicatory proceedings without action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:286 (January 2011).

### §141. Minimum Specifications for Termite Control Work

A. All labels for products used for termite control work shall be registered by the EPA and the department and shall be approved by the commission prior to their use.

1. The department shall issue a listing of product labels approved by the commission for termite control work. The listing shall become effective upon approval by the commission. The list shall be published in the Potpourri Section of the *Louisiana Register* and shall remain in effect until changed by the commission. The commission may add or delete any product labels from its list. The list shall be published in the Potpourri Section of the *Louisiana Register*. Upon publication of the list all previous listings shall be repealed.

2. The commission's list of product labels shall also contain the chemical concentration at which each product label is approved for usage, and shall be applied in accordance with label and labeling requirements and shall not be applied at any less than label and labeling requirements.

B. Requirements for Trench and Treat. All trenches shall be approximately 4 inches wide at the top angled toward the foundation and sufficiently deep (approximately 6 inches) to permit application of the required chemical. Apply the product mixture into the trench at the rate and manner prescribed on the label and labeling. Rodding will be acceptable only when trenching will damage irrigation equipment, flowers and/or shrubs.

#### C. Treatment of Existing Pier Type Construction

##### 1. Access Openings

a. Provide suitable access openings to all crawl-space areas and to all other areas requiring inspection and/or treatment for termites.

b. A minimum clearance of 12 inches from the bottom of the sill.

##### 2. Required Clean-Up

a. Remove all cellulose-bearing debris, such as scrap wood, wood chips, paper, etc., from underneath buildings.

b. Trench, rod and treat any large stumps or roots that are too sound to be removed, provided that such stumps or roots are at least 12 inches from the foundation timbers. Stumps or roots located less than 12 inches from foundation timbers shall be cut off to provide at least 12 inches clearance.

c. Remove all form boards that are not embedded in concrete.

##### 3. Elimination of Direct Contact of Wood with Ground

a. Piers and stiff legs shall have concrete or metal-capped bases extending at least 3 inches above the ground. Pressure-treated piling foundations are exempt from this requirement.

b. Wood parts which extend through concrete or masonry (such as posts, door frames or stair carriages) shall

be cut off and set on metal or concrete bases at least three inches above ground level.

c. Wood steps shall be placed on concrete or masonry bases which extend at least 1 inch above ground level, and beyond the steps in all directions. Multiple-course masonry step supports shall be treated as required in §141.C.7.a, b, c and d.

4. Pipes

a. Remove all packing around pipes for a distance of 3 inches above ground level and/or treat according to label and labeling.

5. Skirting and Lattice-Work

a. All skirting and lattice-work shall rest on solid concrete or brick extending at least 3 inches above the outside grade. This base will be trenched and treated.

b. All skirting and lattice-work resting on ground shall be treated by digging trenches below and under the edge of the skirting and lattice; or

c. There shall be at least 3 inches clearance above outside grade if skirting or lattice-work is suspended.

6. Stucco

a. Where stucco extends to or below grade, dig trenches below and under the edge of the stucco and apply chemical as required by label and labeling.

b. Where ground slabs prevent treatment as required in Subparagraph (a) above, drill and treat slab as required by label and labeling. Where slab is drilled the holes shall be no more than 18 inches apart (unless label requires closer distance).

7. Masonry. Apply chemical to all porous areas, cracks and accessible voids in foundation walls, piers, chimneys, steps, buttresses, etc., as follows.

a. Treat all cracks in concrete

b. Drill holes every second mortar joint, a minimum of 3 holes, in all two-course brick foundations (piers, foundation walls, steps, buttresses, L-shaped and T-shaped piers, etc.) and thoroughly treat wall voids. Holes shall be deep enough to reach the center mortar joint and chemical shall be applied under sufficient time and pressure to treat all cracks and voids. Drilling is not required when solid concrete footing extends above grade level or when wall is capped with solid concrete.

c. Drill holes in mortar joints of all three-course brick foundation walls at the end of every second brick to the depth of the end of the second brick. Apply chemical under sufficient time and pressure to treat all cracks and voids.

d. Drill holes into each compartment of the lowest accessible block of hollow concrete (or other lightweight aggregate) blocks and apply chemical into the openings under sufficient time and pressure to treat the area of the bottom of the foundation. On T-shaped or L-shaped piers the connecting mortar joints (crotches) shall be drilled and treated. Drilling is not required if the opening in the block is accessible.

8. Ground Treatment

a. Trench around each pier and/or foundation of the structure being treated.

b. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (approximately 6 inches) to permit application of the required chemical. Apply the product mixture into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable where trenching will damage irrigation equipment, flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches.

9. Dirt Filled Porches

a. Where the sill or other wood extends to, or below, the under side of the concrete slab, the dirt shall be excavated so as to leave a horizontal tunnel at the junction of slab and foundation wall. The tunnel shall extend the full length of the fill and be at least 12 inches deep (or down to grade) and 12 inches wide. Soil in the tunnel shall be treated with chemical at all points of contact with wall and slab. Supports for the slab shall be erected in the tunnel if

**Excavation of Dirt Filled Porches (Figure 1)**



necessary. Tunnel shall be well ventilated, but care shall be taken to assure that water does not run into those tunnels (see Figure 1).

Figure 1 - Excavation of Dirt Filled Porches

Exception: If, due to construction, it is impractical to break into and excavate dirt-filled areas, a method of drilling, rodding and flooding as outlined in §141.C.9.b.ii below, may be employed.

b. Where the sill or other wood does not extend to or below the underside of the concrete slab, the fills shall be drilled, rodded and flooded as follows.

i. Drill floor slab at intervals of not more than 18 inches (unless label requires closer distance) along the junction of the porch and the buildings: rod and treat the fill along the foundation wall of the building.

ii. When it is impossible to rod and treat fill because of broken concrete, rock or other non-porous material in the fill, drill the floor slab as outlined in §141.C.9.b.i and apply sufficient chemical to treat the surface areas beneath the floor slab. When non-porous materials are present in the fill, drill holes in a multi-course brick foundation at 8 inch intervals with every other hole extending into the fill. When there is a hollow-brick foundation, drill holes into the fill area every 16 inches along the foundation wall.

NOTE: This is in addition to drilling and treating voids as outlined below (see Figure 2 and 3).

Figure 2 - Dirt Filled Porch (Hollow Block)

**Dirt Filled Porch - Hollow Block (Figure 2)**

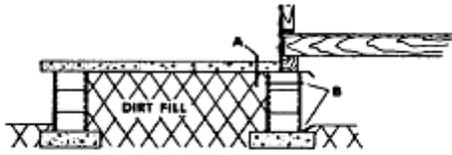
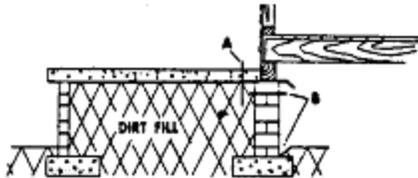


Figure 3 - Dirt Filled Porch (Multi-Course Brick)

**Dirt Filled Porch - Multi-Course Brick (Figure 3)**



c. When treating earth fills (drilling, rodding and excavation), porch foundation walls will be treated as follows.

i. Drill hollow-block walls and apply sufficient chemical to penetrate mortar joints and flow into the trench at the bottom of the foundation wall.

ii. Drill multi-course brick walls at intervals of every second brick and treat all voids, making certain that the chemical flows into the voids on both sides of the hole being treated.

10. Chimney Bases and Dirt Filled Steps. Chimney bases and dirt filled steps shall be treated by drilling the foundation walls as outlined in Step 2 for dirt filled porches, (see Figure 4 and 5).

Figure 4 - Chimney Base

**Chimney Base (Figure 4)**

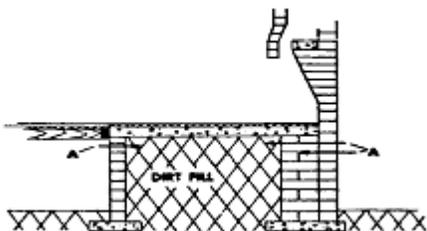
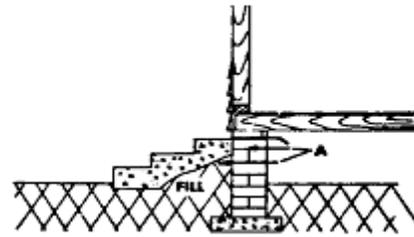


Figure 5 - Dirt Filled Step

**Dirt Filled Step (Figure 5)**



**D. Treatment of Existing Slab-Type Construction**

**1. Ground Treatment**

a. Trench around the entire perimeter of the structure being treated, adjacent to the foundation wall.

b. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (approximately 6 inches) to permit application of the required chemical. Apply the product mixture into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable only where trenching will damage irrigation equipment, flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches.

**2. Bath Traps**

a. An access hole of a minimum of 6 x 8 inches shall be provided to all bathtub plumbing. Specifications shall have a waiver of the listed item or items signed by the owner prior to the treatment. A copy of the signed waiver shall be filed with the department with the monthly Termite Eradication Report.

b. If the soil in a trap does not reach the bottom of the slab, the trap shall be filled to within 2 inches of the top of the slab with soil prior to treatment. Treat bath trap(s) as required by label and labeling.

c. A tar filled bath trap shall also be drilled and treated as required by label and labeling.

d. If bath trap is solid concrete pour, it shall be drilled and treated as close as practical to the bathtub plumbing.

**3. Other Openings in Slab**

a. All showers shall be drilled and treated as close as practical to shower plumbing.

b. Rod under or drill through the slab and treat all areas beneath expansion joints and cracks in the slab as per label and labeling instructions. When the slab is drilled, the holes shall be no more than 18 inches (unless label requires closer distance) apart along the above stated areas.

c. All other openings (plumbing, etc.) shall be treated as required by label and labeling.

#### E. Pre-Treatment of Slabs

1. The permittee or primary licensee shall report the completion of the application to the outside of the foundation to the department on the termite perimeter application form. Within 12 months after initial treatment, the outside perimeter of the foundation will be treated as follows:

a. trench around the entire perimeter of the structure being treated, adjacent to the foundation wall. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (approximately 6 inches) to permit application of the required chemical. Apply the product mixture into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable where trenching will damage irrigation equipment, flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches;

b. rod under or drill through any slab(s) adjoining or abutting the initial pre-treated slab and treat all areas beneath adjoining or abutting slab(s) as per label and labeling instructions. When any slab(s) is drilled, the holes shall be no more than 18 inches (unless label requires closer distance) apart along the above stated areas.

2. If, during the treatment of any area which will be beneath a slab foundation, the operator shall leave the site for any reason prior to the completion of the application, the operator shall prominently display a poster, approved by the department, which states that the treatment of the area under the slab is not complete.

3. All pre-treatment of slabs ~~must~~ shall be called or faxed to the department's district office in which the pretreat occurs, a minimum of 1 hour prior to beginning the application of termiticides. The information provided shall include treatment company name; treatment structure street address, city, parish; directions to the property being pre-treated; date and time of beginning the application of termiticides to the property; square or linear footage of each structure to be treated; and number of structures. All pest control operators shall keep a log of all pretreats including the information noted. The following is a list of parishes in each of the department's seven district offices. Pre-treatments in a parish shall be called into the corresponding district office.

a. Shreveport District—Caddo, Bossier, Webster, Claiborne, Bienville, Red River, and Desoto.

b. Monroe District—Union, Morehouse, West Carroll, East Carroll, Madison, Richland, Ouachita, Lincoln, Jackson, Winn, Caldwell, Franklin, Tensas, Concordia, and Catahoula.

c. Alexandria District—Sabine, Natchitoches, Grant, LaSalle, Avoyelles, Rapides, and Vernon.

d. Crowley District—Beauregard, Allen, Acadia, Jefferson Davis, Cameron, Calcasieu.

e. Opelousas District—Evangeline, St. Landry, St. Martin, Iberia, St. Mary, Vermillion, and Lafayette.

f. Baton Rouge District—Pointe Coupee, West Feliciana, East Feliciana, St. Helena, Tangipahoa, Washington, St. Tammany, Livingston, St. James, Lafourche, Terrebonne, Assumption, Ascension, Iberville, West Baton Rouge, and East Baton Rouge.

g. New Orleans District—St. John the Baptist, St. Charles, Jefferson, Orleans, St. Bernard, and Plaquemines.

#### F. Spot Treatment

1. Spot treatments shall not be done on pier-type or slab construction except where a waiver of minimum specifications has been obtained from the owner of the property. All buildings that can not be treated according to the minimum specifications shall have a waiver of the item or items signed by the owner prior to the treatment. A copy of the signed waiver shall be filed with the department with the monthly Termite Eradication Report.

2. Treatment will be allowed to any additions to the main structure or exterior slab enclosures and a fee shall be paid and a contract issued on this addition unless the main structure is under contract with the firm performing the treatment on this addition.

3. Each spot treatment reported on the Wood-Destroying Insect Eradication Report shall include a waiver of minimum specifications and a complete diagram of the area(s) treated.

#### G. Infested Properties

1. Whenever any agent of the department finds that any property is infested with termites, the operator who treated the property shall retreat within 30 days after receipt of notification from the department.

2. When the pest control operator completes the re-treatment, he shall notify the department within 5 working days.

#### H. Responsibility of Pest Control Operator

1. The pest control operator shall notify the property owner/agent of the presence of any visible insect damage found in portions of the building that are accessible for inspection.

2. The pest control operator shall provide for an air space or a backflow preventer on the water hose used in supplying water to the chemical tank.

I. Waiver of Requirements of Minimum Specifications for Termite Control Work

1. A pest control operator may request from the owner/agent of the structure(s) to be treated, a waiver of the requirements set out in these regulations whenever it is impossible or impractical to treat one or more areas of the structure in accordance with these minimum specifications for initial treatment. The waiver shall be signed by the owner/agent of the structure(s) to be treated prior to or during treatment. A signed copy of the waiver shall be given to the owner/agent and shall be sent to the department with the company's monthly eradication report. The waiver shall include, but not be limited to, the following information:

a. graph identifying the structure and the specific area(s) where treatment is waived;

b. a description of each area where treatment is waived; and

c. for each area, the reason treatment is being waived.

2. A pest control operator may request, from the owner/agent of the structure(s) to be treated, a waiver of the requirements set out in these regulations whenever it is impossible or impractical to treat one or more areas of the structure in accordance with these minimum specifications for Retreat(s). The waiver shall be signed by the owner/agent of the structure(s) to be treated prior to or during treatment. A signed copy of the waiver shall be given to the owner/agent and shall be made available to the department

upon reasonable request. The waiver shall include, but not be limited to, the following information:

- a. a graph identifying the structure and the specific area(s) where treatment is waived;
- b. a description of each area where treatment is waived; and
- c. for each area, the reason treatment is being waived.

J. Requirements for Baits and Baiting Systems

1. Any licensee or any person working under the supervision of a licensee, who applies baits and/or baiting systems, shall be certified in the use of the baits and baiting systems, by the manufacturer of the product, prior to any application of the bait or baiting system. Manufacturer certification and training programs shall have department approval of the agenda prior to the program presentation.

2. All baits and baiting systems applications shall be contracted and reported according to R.S.3:3370 and LAC7:XXV.119. D and pay the fee as described in LAC 7:XXV.119.E.

3. Bait and baiting systems shall be used according to label and labeling.

4. Above ground bait stations shall be used according to their label and labeling when the presence of subterranean termites are detected in the contracted structure.

5. All bait stations, except those products in the pilot project, shall be monitored/inspected according to the label and labeling.

6. Monitoring and ground bait stations shall surround the contracted structure and shall not be more than 20 feet apart, where soil is available unless the label requires stations closer and/or does not allow for "where soil is available."

7. Monitoring and ground bait stations, where soil is available, shall be no further than 20 feet from the slab or pier's outside perimeter except for non-structural wood elements including but not limited to trees, stumps, wood piles, landscape timbers and detached fences.

8. Records of contracts, graphs, monitoring, and bait applications shall be kept according to LAC 7:XXV.117.I.

9. A consumer information sheet, supplied by the manufacturer and approved by the commission, shall be supplied to the registered pest control operator. The pest control operator shall, in turn, supply a copy of the consumer information sheet to all persons contracted.

10. All monitoring and bait stations shall be removed by the pest control operator from the contracted property within 30 days of the termination of the contract. In the event the bait and baiting system manufacturer stops the use by the pest control operator of their bait and baiting system; all monitoring and bait stations shall be removed by the pest control operator from the contracted property within 90 days of the stop use notification.

11. The commission hereby establishes a pilot program for the use of bait and baiting systems and shall include but not be limited to the following:

- a. all baits and baiting systems products shall be subject to the pilot project for a period of a minimum of one year. The commission shall reevaluate the products in the pilot program prior to the end of the first quarter of every calendar year;

- b. pilot project bait and baiting system products shall, upon approval of the commission, be listed in the *Louisiana Register*;

- c. pilot project bait and baiting system products are subject to all regulations in LAC 7:XXV.141.J;

- d. baits and baiting systems may be used as a stand-alone termite treatment only with written approval by LDAF;

- e. baits and baiting systems may be used as a supplement to traditional ground termiticide treatments.

- f. ground bait delivery shall begin when the presence of subterranean termites are detected in the monitoring station or if the label allows, Ground bait stations may be used as monitoring stations and inspected as required in LAC 7:XXV.141.J.11.

- g. Ground monitoring and bait stations, used as monitors, shall be inspected monthly, not to exceed 35 days, from the date of installation or last inspection. When there is no termite feeding on any bait or monitoring station for 90 days from the date of installation or last inspection; monitor as required in LAC 7:XXV.141.J.11.

- h. When there is termite feeding on any bait and/or monitoring station(s) at the contracted structure; all above ground bait stations and ground monitoring and bait stations shall be inspected monthly, not to exceed 35 days from the date of installation or last inspection and such inspections shall continue until there is no termite feeding on any bait and/or monitoring station, in any station, at the contracted structure for 90 days from the date of installation or last inspection; When there is no termite feeding on any bait or monitoring station for 90 days from the date of installation or last inspection; monitor as required in LAC 7:XXV.141.J.11.

- i. When there is no termite feeding on any bait or monitoring station for 90 days from the date of installation or last inspection; monitoring shall resume at regular intervals, not to exceed 90 days from the date of the last inspection; when termites are detected again, monitoring and/or baiting shall follow the requirements set forth in LAC 7:XXV.141.J.11.

- j. pilot project bait and baiting system products are subject to all regulations in LAC 7:XXV.141.J;

K. Requirements for Combination Liquid Spot and Baits and Baiting Systems Treatments

1. Any licensee or any person working under the supervision of a licensee, who applies a combination liquid spot and baits and/or baiting systems treatments, shall be certified in the use of the baits and baiting systems, by the manufacturer of the product, prior to any application of the bait or baiting system.

2. Combination of liquid spot and bait and baiting systems treatments shall be used according to label and labeling.

3. All combination liquid spot and baits and baiting systems treatments shall be contracted and reported according to R.S. 3:3370 and LAC 7:XXV.119.E and pay the fee as described in LAC 7:XXV.119.F.

4. Records of contracts, graphs, monitoring (if required), and applications shall be kept according to LAC 7:XXV.117.I. At termination of the contract, the pest control

operator shall remove all components of bait and baiting systems.

5. All structures that cannot be treated according to the combination liquid spot and bait and baiting systems treatment minimum specifications shall have a waiver of the listed item or items signed by the owner prior to the baiting treatment. A copy of signed waiver shall be filed with the department with the monthly termite eradication reports.

6. A bait and baiting systems consumer information sheet, supplied by the manufacturer and approved by the commission, shall be supplied to the registered pest control operator. The pest control operator shall, in turn, supply a copy of the consumer information sheet to all persons contracted.

7. Combination liquid spot and bait and baiting systems treatment of existing slab-type construction shall bait following the label and labeling and liquid spot treat to the following minimum specifications:

a. Trench and treat 10 feet on both sides of live subterranean termite infestation site(s) around the perimeter of the structure, adjacent to the foundation wall. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (minimum 6 inches) to permit application of the required chemical. Apply the emulsion into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable only where trenching will damage irrigation equipment, flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches.

b. Rod under or drill through abutting slab(s) and treat all areas in the abutting slab(s) within the 20 feet as required in LAC 7:XXV.141.K.7.a. When the abutting slab is drilled, the holes shall be no more than 18 inches apart, unless label requires closer distance along the above stated areas.

c. Treat bath trap(s) as per label and labeling. Bath trap(s) access hole of a minimum of 6 x 8 inches shall be provided to all bathtub plumbing.

i. If the soil in a trap does not reach the bottom of the slab, the trap shall be filled to within 2 inches of the top of the slab with soil prior to treatment. Treat bath trap(s) as required by label and labeling.

ii. A tar filled bath trap shall also be drilled and treated as required by label and labeling.

iii. If bath trap is solid concrete pore, it shall be drilled and treated as close as practical to the bathtub plumbing.

d. All showers shall be drilled and treated as close as practical to shower plumbing according to label and labeling.

e. All other openings (plumbing, etc.) shall be treated as required by label and labeling.

8. Combination liquid spot and bait and baiting systems treatments of existing pier-type construction with live subterranean termite infestation(s) shall bait following the label and labeling and liquid treat to the following minimum specifications.

a. Trench and treat 10 feet on both sides of infestation site(s) on brick/block chain wall(s) and all piers within 10 feet of an infested pier or chain wall. Trench, drill, and treat as required in LAC 7:XXV.141.

9. Combination liquid spot and bait and baiting systems treatment of existing slab-type construction and pier-type construction without live subterranean termite infestation(s) shall bait following the label and labeling and liquid treat as required in LAC 7:XXV.141.K.7.c-e.

10. Whenever any property under a combination liquid spot and bait and baiting systems treatment contract becomes infested with subterranean termites, the operator shall treat the property according to the minimum specifications as stated in LAC 7:XXV.141.K.

#### L. Requirements for Retreats

1. Retreatment of existing slab-type construction shall treat following the label and labeling and the following minimum specifications.

a. Trench and treat 10 feet on both sides of live subterranean termite infestation site(s) and/or a breach(s) in the treated zone around the perimeter of the structure, adjacent to the foundation wall. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (minimum 6 inches) to permit application of the required chemical. Apply the emulsion into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable only where trenching will damage irrigation equipment, e flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches.

b. Rod under or drill through abutting slab(s) and treat all areas in the abutting slab(s) within the 20 feet as required in LAC 7:XXV.141.L.1.a. When the abutting slab is drilled, the holes shall be no more than 18 inches apart along the above stated areas unless the label requires closer distance.

c. Treat bath trap(s) as per label and labeling when live subterranean termites or a breach(s) in the treated zone occur. Bath trap(s) access hole of a minimum of 6 x 8 inches shall be provided to all bathtub plumbing.

i. If the soil in a trap does not reach the bottom of the slab, the trap shall be filled to within 2 inches of the top of the slab with soil prior to treatment. Treat bath trap(s) as required by label and labeling.

ii. A tar filled bath trap shall also be drilled and treated as required by label and labeling.

iii. If bath trap is solid concrete pour, it shall be drilled and treated as close as practical to the bathtub plumbing.

2. Retreatments of existing pier-type construction with a live subterranean termite infestation(s) and/or a breach(s) in the treated zone shall liquid treat to the following minimum specifications.

a. Trench and treat 10 feet on both sides of a breach(s) in the treated zone or an infestation site(s) on chain wall(s) and all piers within 10 feet of an infested or breached pier or chain wall. Trench, drill, and treat as required in LAC 7:XXV.141.

3. Minimum specification treatments shall not include areas properly waived in initial treatment contract.

#### M. Requirements for Borates Pre-Construction Treatments

1. Treat according to the borate label.

2. A perimeter soil treatment shall be applied within 12 months after initial treatment, the outside perimeter of the foundation, shall be treated as follows:

a. trench around the entire perimeter of the structure being treated, adjacent to the foundation wall. All trenches shall be approximately 4 inches wide at the top, angled toward the foundation and sufficiently deep (approximately 6 inches) to permit application of the required chemical. Apply the product mixture into the trench at a rate and manner prescribed on the label and labeling. Rodding will be acceptable where trenching will damage flowers and/or shrubs. Maximum distance between rod holes shall be 4 inches;

b. rod under or drill through any slab(s) adjoining or abutting the slab and treat all areas beneath adjoining or abutting slab(s) as per label and labeling instructions. When any slab(s) is drilled, the holes shall be no more than 18 inches (unless label requires closer distance) apart along the above stated areas;

3. treat bath traps as per termiticide label and labeling or as follows:

a. if the soil in a trap does not reach the bottom of the slab, the trap shall be filled to within 2 inches of the top of the slab with soil prior to treatment. Treat bath trap(s) as required by label and labeling;

b. a tar filled bath trap shall also be drilled and treated as required by label and labeling;

c. if bath trap is solid concrete pour, it shall be drilled and treated as close as practical to the bathtub plumbing;

4. if, during the treatment of any area, the operator shall leave the site for any reason prior to the completion of the application, the operator shall prominently display a poster at the treatment site, which states that the treatment of the area is not complete;

5. the treatments of structures required in this section shall be called or faxed to the department's district office in which the treatment occurs, a minimum of one hour prior to beginning the application of termiticides. The information provided shall include: treatment company name; treatment structure street address, city, parish; directions to the property being pre-treated; date and time of beginning the application of termiticides to the property; square or linear footage of the each structure to be treated; and number of structures. Permittees or licensees shall keep a log of all pretreats including the information noted. The following is a list of parishes in each of the department's seven district offices. Treatments in a parish shall be called into the corresponding district office:

a. Shreveport District—Caddo, Bossier, Webster, Claiborne, Bienville, Red River, and Desoto;

b. Monroe District—Union, Morehouse, West Carroll, East Carroll, Madison, Richland, Ouachita, Lincoln, Jackson, Winn, Caldwell, Franklin, Tensas, Concordia, and Catahoula;

c. Alexandria District—Sabine, Natchitoches, Grant, LaSalle, Avoyelles, Rapides, and Vernon;

d. Crowley District—Beauregard, Allen, Acadia, Jefferson Davis, Cameron, Calcasieu;

e. Opelousas District—Evangeline, St. Landry, St. Martin, Iberia, St. Mary, Vermillion, and Lafayette;

f. Baton Rouge District—Pointe Coupee, West Feliciana, East Feliciana, St. Helena, Tangipahoa, Washington, St. Tammany, Livingston, St. James, Lafourche,

Terrebonne, Assumption, Ascension, Iberville, West Baton Rouge, and East Baton Rouge;

g. New Orleans District—St. John the Baptist, St. Charles, Jefferson, Orleans, St. Bernard, and Plaquemines;

6. all borate treatments shall be contracted and reported as provided by R.S. 3:3370 and §119.E of this Part and the fee for each such contract shall be paid in accordance with §119(F) of this Part;

7. records of contracts, graphs, monitoring (if required), and applications shall be kept as required by §117.I;

8. all retreatments shall be as required by §141.L of this Part;

9. the permittee or licensee shall report the completion of the application to the outside of the foundation to the department on the termite perimeter application form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:958 (November 1989), LR 20:644 (June 1994), LR 21:931 (September 1995), LR 23:1285 (October 1997), LR 25:235 (February 1999), LR 25:1620 (September 1999), LR 26:2437 (November 2000), LR 27:1180 (August 2001), LR 29:1063 (July 2003), LR 30:1145 (June 2004), repromulgated LR 30:1614 (August 2004), amended LR 35:207 (February 2009), LR 35:1469 (August 2009), repromulgated LR 35:1872 (September 2009), amended, LR 37:286 (January 2011).

#### **§143. Termiticide Foam Applications**

A. Termiticide foam applications may be used as a supplemental treatment to approved liquid applications on treatments for the control, prevention or eradication of termites and other wood destroying insects.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 19:1010 (August 1993); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:292 (January 2011).

#### **§145. Wood-Destroying Beetles**

A. An active infestation of wood destroying beetles, as described below, shall be found by the pest control operator prior to recommending entering into a contract, applying a treatment, or performing a service to control or eradicate the infestation.

1. Powder Post Beetle (Anobiidae, Bostrichids and Lyctidae)

a. Power post beetle frass shall be exuding or streaming from the holes on the outside of the wood or live larvae or pupae are found in the wood members.

2. Old House Borer (*Hylotrupes bajulus*)

a. The presence of live larvae or pupae, adult beetles or oblong exit holes with frass in pine or other softwoods will be evidence of active infestation of the old house borer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:332 (April 1985), amended LR 35:1470 (August 2009), LR 37:292 (January 2011).

## §147. Fumigation

### A. General

1. This rule governs all fumigation of residential and commercial structures, ships, railcars, trucks, commodity containers and vaults within the state of Louisiana, including ships at anchor in rivers within the borders of Louisiana and ships at anchor within a 3-mile limit off the coast of Louisiana.

2. The licensee shall not only comply with the Structural Pest Control Commission rules and regulations but shall follow all other applicable state and federal rules and regulations.

3. The licensee is responsible for compliance with all label and labeling requirements.

4. The licensee is responsible for giving any notice to law enforcement and/or fire protection agencies required by any governing body of the locality in which the fumigation will take place.

5. The licensee shall make certain that personal protection equipment for the fumigant being used is immediately accessible where the fumigation is being done.

6. The licensee or his certified fumigation technician shall remove all signs, fumigation containers and/or materials, and any other debris which accumulated as a direct result of the fumigation.

### B. Requirements for Structural Fumigation

1. The permittee or primary licensee shall give notice, in writing, to be received by the department at least 24 hours prior to structural fumigation. Notice to the department shall include the following items:

- a. time and place where the fumigation will take place;
- b. name, address and emergency phone number of the licensee;
- c. name of the fumigant to be used;
- d. a brief description of the property to be fumigated;
- e. target pest;
- f. location of target pest; and
- g. other information the commission requests.

2. When notice cannot be given as required by §147.B.1, notice shall be given by phone but shall be confirmed in writing, to be received by the commission within 24 hours after the telephone notice.

3. A licensed fumigator shall personally inspect all structures that are to be fumigated while they are being tented or sealed after the structure has been evacuated.

4. A licensed fumigator or his certified fumigation technician shall seal or supervise the sealing of the area to be fumigated and assure that there is proper and secure sealing to confine the fumigant to the area that is to be fumigated, prior to the release of the fumigant.

5. A licensed fumigator or his certified fumigation technician shall see that a sign or signs of sufficient size as to be conspicuous and bearing the word "poison" and the skull-and-crossbones symbol, is prominently displayed at all entrances to the area being fumigated continuously from the time the area is sealed until ventilation is completed.

6. When tarp fumigation is being used, in addition to the signs on each entrance of the building, there shall be at

least one sign on each side of the exterior tarp. If any side of the building exceeds 35 feet, additional signs will be added. The maximum distance between signs of any side of a building will be 60 feet.

7. Two test lines with at least 1/4 inch outside diameter shall be appropriately located on the first floor of the structure(s) being fumigated to permit sufficient readings of the fumigant concentrate to determine its efficacy in destroying insects. They shall be on opposite sides of the building. In multi-story buildings the lines shall be on different floors. A written record of fumigant level readings shall be maintained during progress of job and will become part of job file.

8. A licensed fumigator shall post a guard(s) to prevent entry by an unauthorized person into the area being fumigated. The guard is not required to be a licensed pest control operator or registered employee.

9. Whenever one unit of a complex containing more than one unit is to be fumigated, all units of the building to be fumigated shall be evacuated during fumigation and until such time as the fumigated area is declared safe for occupancy. A licensed fumigator shall inspect all units of a complex.

10. A licensed fumigator or his certified fumigation technician shall be present when the fumigant is released and immediately prior to the time when the fumigated area is declared safe for occupancy. At least one other person, trained in fumigation in addition to the above, ~~must~~ shall be present when the fumigant is released and immediately prior to the time when the fumigation area is declared safe for occupancy.

11. A licensed fumigator or his certified fumigation technician shall personally inspect the area which was fumigated when ventilation is completed to assure that the fumigated area, and adjacent areas as appropriate, is safe for occupancy.

### C. Requirements for Shipboard Fumigation

1. A licensed fumigator shall be present for the initial application of fumigant.

2. A licensed fumigator is responsible to declare the ship safe for occupancy.

D. Requirements for Commodity Fumigation. A licensed fumigator or certified fumigation technician shall:

1. check inside the container along the junctures to be sealed before fumigation;

2. all openings in vehicles being fumigated must be sealed;

3. inside and outside warning signs shall be posted as required by labeling and label requirements;

4. after releasing the fumigant, check for leakage and repair any leaks which occur;

5. the permittee or licensed fumigator licensee shall notify the consignee, in writing, of the fumigant being used, antidotes and the proper procedures for handling any vehicle(s) or commodity container(s) which is shipped under gas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3306.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 11:332 (April 1985), amended LR 17:251 (March 1991), LR 37:293 (January 2011).

#### **§149. Repeal of Prior Rules and Regulations of the Commission**

A. Upon promulgation of these rules and regulations, all rules and regulations of the commission adopted prior to the effective date of these rules and regulations shall be repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:334 (April 1985); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:294 (January 2011).

#### **§151. General Requirements for Pesticide Waste**

A. All licensees\commercial applicators applying pesticides which, upon disposal, are classified as waste shall implement a containment system for reuse or apply the waste immediately to the site of application per label and labeling.

B. Handling Spills by Licensees\Commercial Applicators

1. All spills of more than 1 gallon liquid or 4 pounds dry weight shall be reported to the director by the applicator, primary licensee or permittee within 24 hours by telephone and by written notice within three days.

2. The permittee is responsible for the cost of cleanups resulting from pesticide spills in their operations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:294 (January 2011).

#### **§153. Procedures Governing Handling of Pesticide Containers (Except Bulk Pesticide Containers)**

A. Storage Areas for Full or Partially Full Pesticide Containers

1. Pesticide containers shall be stored in a secure, locked enclosure.

2. Pesticide containers shall be free of leaks.

3. The storage area shall be maintained in good condition, without unnecessary debris.

B. Empty containers shall be stored in a secured area. Empty containers shall be kept for no more than 30 days.

C. Metal, Glass and Plastic Containers

1. All metal, glass and plastic containers shall be triple-rinsed, immediately after the pesticide is removed by the following, or equivalent procedure.

a. Using a solvent capable of removing the pesticide, fill each container with solvent equal to approximately 10 percent of the volume of pesticide originally contained in the container.

b. Agitate the solvent thoroughly on all interior surfaces of the container. Agitation shall be accomplished by use of agitation equipment approved by the department or by manual agitation of the solvent.

c. Repeat the above procedure three times.

d. If the rinsate containing the solvent can be used again in subsequent application of the pesticide without reducing the effectiveness of the pesticide, place the rinsate in the containment tank specified for that pesticide.

2. Upon completion of the above triple-rinsing procedures, containers shall be disposed of in one of the following ways:

a. by disposal in any permitted solid waste facility (sanitary landfill), provided that, prior to disposal in a solid waste facility, the pesticide applicator shall pierce all metal and plastic containers in both ends;

b. by prior agreement, by return (for credit or otherwise) to the pesticide sales agent or the pesticide manufacturer; or

c. by transfer to a third party for recycling or reconditioning.

D. Paper and Plastic Bags

1. All pesticides shall be removed from paper and plastic bags to the maximum extent possible when the pesticide is initially mixed for application. Thereafter, containers shall be disposed of as follows.

a. Cut all sides of the container and open the container fully, without folds or crevices, on a flat surface, shake any pesticides remaining in the open container into the pesticide mix.

b. After cutting and flattening such pesticide containers, dispose of containers in a solid waste facility (sanitary landfill).

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:294 (January 2011).

#### **§155. Procedures for Constructive Recycling by Commercial Applicators of Unused Portions of Pesticides and/or Rinsate of Pesticides which, upon Disposal are Classified as Hazardous Wastes under EPA Regulations**

A. Applicators of pesticides covered under this rule may recover and constructively reuse any unused portions of such pesticides and/or any rinsate of such pesticides by one of the following methods:

1. by immediate reapplication of the unused portion of the pesticide and/or the rinsate in accordance with label and labeling requirements for that pesticide;

2. by transferring to a closed containment system meeting the requirement of §157; or

3. by disposal in a permitted hazardous waste facility.

B. All unused pesticides and/or rinsate from pesticides classified as a waste upon disposal shall be removed from containment tanks in less than 30 days after deposit therein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:294 (January 2011).

#### **§157. Containment System**

A. Containment Tanks

1. Different containment tanks shall be installed for different pesticides and/or rinsate of pesticides, except the same containment tanks may be used for two or more pesticides when such pesticides are physically and chemically compatible and when their mixing is not prohibited by their labels.

2. Each containment tank shall meet the following requirements:

- a. shall be constructed of material of sufficient strength and be compatible with the pesticide and/or rinsate to be placed within the tank;
- b. shall be free of leaks, cracks, holes or other deterioration at all times;
- c. shall be in good operating order at all times;
- d. shall be designed to allow drainage of the entire contents and be triple rinsed;
- e. shall be equipped with stopcocks, at appropriate locations, to prevent any leakage of the contents during storage or transfer of the contents; and
- f. shall be equipped with an opening to allow for sampling.

**B. Containment Tank Foundation**

- 1. The containment tank foundation shall be solidly constructed of a material sufficiently impervious to contain leaks, spills and accumulated pesticides and/or rinsate of pesticides.
- 2. The foundation covering shall not be free of cracks which might allow leakage.
- 3. The foundation shall be sloped to facilitate cleanup of inadvertent spills.
- 4. The foundation shall be constructed with a rim of sufficient height to contain run-off from cleanup activities or inadvertent spills and be protected from flood waters.
- 5. The foundation shall be so constructed as to discharge all liquids into a dump.
- 6. Tanks shall be located at sufficient elevation to allow visual detection of leakage of the contents.

C. Storage Requirements. All containment tank(s) shall be located in a secured area and protected from flood waters.

D. Location Requirements; Submission of Preliminary Site Plans. Containment systems shall be located a suitable distance from any adjacent buildings, property lines, or public access roads. Site plans showing location of the containment system shall be submitted for the approval of the commission prior to construction. These plans may be rudimentary; the purpose of such submission is to avoid unnecessary expense by the application.

E. Requirements for Final Approval of Containment Systems. Final plans and specifications for construction of a closed containment system shall be approved by the commissioner and shall be filed with the department, subject to the approval of the commission, prior to the start of construction. In consideration for approval of such plans and specifications, the commission may, at their discretion, be assisted by an ad hoc advisory committee consisting of such experts as may be appointed by the commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:294 (January 2011).

**§159. Management of Unused Portions of Pesticides and/or Rinsate of Pesticides Which, upon Disposal, Are Not Classified as Hazardous Wastes under EPA Regulations**

A. Unused portions of pesticides and/or rinsate resulting from the application of pesticides not classified as a hazardous waste upon disposal shall be handled by one of the following methods:

- 1. by subsequent, immediate reapplication in accordance with label and labeling requirements for the pesticide;
- 2. by deposit in a closed containment system which meets the requirements of §157 hereof;
- 3. by disposal in surface impoundments which meet the requirements of this rule; or
- 4. any other methods approved by the commission.

B. Whenever violative levels of pesticides classified as a hazardous waste upon disposal are detected in any sample taken from a containment tank, whether the containment tank was in operation at the effective date of these regulations or installed after the effective date of these regulations, such containment tank shall be immediately and permanently closed and, if closed, all contents thereof shall be removed and disposed of at a permitted hazardous waste disposal facility. The financial responsibility of closing a surface impoundment belongs to the commercial applicator and/or property owner.

C. Insofar as the disposal of a pesticide waste is concerned, commercial applicators who generate hazardous pesticide waste and who do not comply with these regulations shall be subject to the regulations governing hazardous pesticide waste under the jurisdiction of the Department of Environmental Quality until such time as the commissioner of agriculture promulgates regulations governing hazardous pesticide waste.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 12:285 (May 1986); amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:295 (January 2011).

**§161. List of Approved Termiticides**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 20:644 (June 1994), amended LR 21:671 (July 1995), repealed LR 37:295 (January 2011).

**§163. Donation of Structural Pest Control Work**

A. Structural pest control operators licensed by the commission may donate, in accordance with this Section, structural pest control work to eligible individuals or organizations who otherwise could not afford such services in order to improve living conditions and their quality of life.

B. The commission, at the request of the Louisiana Pest Control Association or any other state or local not-for-profit association of pest control operators, may approve a plan for the donation of structural pest control work to individuals or organizations that are in need of, but unable to afford such services.

C. Any plan submitted to the commission shall state:

- 1. the purpose of the plan;
- 2. the organization(s) or group(s) of persons receiving such services;
- 3. the nature of the services to be provided;
- 4. the location(s) at which the services are to be provided;
- 5. the length of time the program is to run;
- 6. the licensed pest control operators who are expected to participate;

7. any other information the commission may deem necessary to properly evaluate the plan.

D. Upon approval of any such plan by the commission, the department shall suspend:

1. the fee for termite contracts required under §117.M of this Part; and

2. the requirements of §119 of this Part pertaining to contracts.

E. The rules and regulations suspended by Subsection D above are waived only for the duration of the program and only in connection with structural pest control work performed by participating licensed pest control operators on buildings and structures at the specific locations listed in the approved plan.

F. The month of June is the Louisiana Pest Control Month. All programs for the donation of pest control work shall begin in June and end at the time specified in the plan that is submitted and approved by the Structural Pest Control Commission. The commissioner may, for exceptional circumstances, approve a plan to begin in a month other than June.

G. A copy of the approved plan, showing the list of specific eligible locations and the beginning and ending dates of the program shall be published in the potpourri Section of the *Louisiana Register* at least 30 days prior to the beginning of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 24:1262 (July 1998), amended LR 37:295 (January 2011).

#### **§165. Excavation of Dirt Filled Porches (Figure 1)**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:334 (April 1985), repealed by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:296 (January 2011).

#### **§167. Dirt Filled Porch (Hollow Block) (Figure 2)**

Repealed

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:335 (April 1985), repealed by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:296 (January 2011).

#### **§169. Dirt Filled Porch (Multi-Course Brick) (Figure 3)**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:335 (April 1985), repealed by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:296 (January 2011).

#### **§171. Chimney Base (Figure 4)**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:335 (April 1985), repealed by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:296 (January 2010).

#### **§173. Dirt Filled Step (Figure 5)**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:335 (April 1985), repealed by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 37:296 (January 2011).

Mike Strain DVM  
Commissioner

1101#073

#### **RULE**

#### **Department of Economic Development Office of Business Development**

#### **Enterprise Zone Program (LAC 13:I.Chapter 7)**

The Department of Economic Development, Office of Business Development, as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., hereby repeals Section 705, and amend and reenact Sections 701 through 703 and Sections 707 through 749 of the Enterprise Zone Program as LAC 13:I.Chapter 7.

#### **Title 13**

#### **ECONOMIC DEVELOPMENT**

#### **Part I. Financial Incentive Programs**

#### **Chapter 7. Enterprise Zone Program**

#### **§701. Scope and Qualifications**

A. Intent of Program. The intent of the program is to stimulate employment for residents in depressed areas of the state that are designated as enterprise zones by providing tax incentives to a business hiring from these areas.

B. Description of Program. The Louisiana Enterprise Zone Program is a jobs program that gives tax incentives to a business hiring from certain specified targeted groups of individuals. Enterprise Zone Program incentives are in addition to other state-sponsored incentives such as the Industrial Tax Exemption Program and the Restoration Tax Abatement Program. Enterprise Zone and Quality Jobs Programs are mutually exclusive.

C. Incentives. The following incentives are available:

1. a one-time tax credit of \$2,500 for each net new job;

2. in lieu of the §701.C.1 tax credit, a one-time tax credit of \$5,000 for each net new job for the following businesses:

a. aviation and aerospace industries as defined in the NAICS industries 336411, 336412, 336413 or 332912;

b. the rubber manufacturing industry as defined in the NAICS industry 326211 (until June 30, 2012); or

c. auto parts manufacturers as defined in the NAICS industry group 3363 (until June 30, 2009);

3. in addition to the §701.C.1 and §701.C.2 tax credits, a one-time tax credit of \$2,500 for each recipient of Temporary Assistance for Needy Families (TANF) hired by a business. The TANF recipient must receive compensation which will disqualify them from continued participation in TANF and must be employed for two years to generate the additional tax credit. An employer shall not obtain the jobs tax credit for more than 10 TANF employees in the first year of participation in the program;

4. rebates of sales and use taxes imposed by the state, and sales and use taxes imposed by its political subdivisions upon approval of the governing authority of the appropriate taxing political subdivision, on all eligible purchases during a specified project period of not more than 30 months:

a. sales and use taxes imposed by a political subdivision which are dedicated to the repayment of bonded indebtedness or dedicated to schools shall not be eligible for rebate;

b. a business seeking a local sales and use tax rebate must obtain an endorsement resolution specific to the project from each political subdivision levying the taxes to be rebated. The endorsement resolution must clearly state the intention to rebate sales and use taxes as allowable for the project. The endorsement resolution must be adopted prior to board approval of the application, or if the project cost is greater than one hundred million dollars, prior to the project ending date;

5. in lieu of the §701.C.4 rebates, a refundable investment tax credit equal to one and one-half percent of the amount of qualified expenditures for assets that are located at the project site and are placed in service during the project period.

D. The §701.C1, §701.C2, and §701.C3 tax credits may be used to satisfy state income tax and franchise tax liabilities, and may be taken on the tax return for the year in which the credit was created, or it may be taken on the tax return for a future year. If the entire tax credit cannot be used in the year created, the remainder may be applied against state income tax and franchise tax liabilities for the succeeding 10 years from the year in which the credit was created or until the entire credit is used, whichever occurs first.

#### E. Qualifications

1.a To qualify for the Enterprise Zone Program, a business must create permanent full-time net new jobs that are at least equal to the lesser of:

i. five jobs, created within the first two years of the contract period; or

ii. the number of jobs equal to a minimum of ten percent of the employees employed throughout the United States by the business and its affiliates, a minimum of one, created within the first year of the contract period.

b. For good cause shown, the board may grant an extension of not more than two years to comply with the above job creation requirements.

2. For projects with advance notifications filed with Business Incentives Services prior to the effective date of the 2010 revision of these rules, qualification will be determined in accordance with prior policy and practice.

3. Residential developments, (including but not limited to the construction, selling, or leasing of single-family or multi-family dwellings, apartment buildings, condominiums, town houses, etc.), churches, and businesses with gaming on site (see LAC 13:I.Chapter 3, Gaming Ineligibility) are not eligible for enterprise zone benefits.

4. For a multi-tenant facility to be eligible for the benefits of this Chapter, the business must meet one of the following criteria:

a. occupy a minimum of 33 percent of the total floor area of the building;

b. tenants are businesses new to the state;

c. tenants are Louisiana businesses increasing their number of locations within the state by placing a new location within this facility;

d. tenants are relocating within Louisiana and will generate the minimum of new job credits over and above the total jobs at their previous location.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 17:252 (March 1991), amended by Department of Economic Development, Office of Commerce and Industry, LR 22:446 (June 1996), amended by the Department of Economic Development, Office of Business Development, LR 29:2298 (November 2003), LR 37:296 (January 2011).

### §703. Definitions

#### *Affiliate*—

1. any business entity that is:

a. controlled by the business;

b. a controlling owner of the business; or

c. controlled by an entity described in Subparagraph a or b.

2. *Control*, for purposes of this definition, means owning either directly or indirectly through control of or by another business entity:

a. a majority of the voting stock or other voting interest of such business entity or the business; or

b. stock or other interest whose value is a majority of the total value of such business entity or the business.

3. A controlled or controlling business entity will be deemed a “non-affiliate” (not an *affiliate*) if LED determines that neither the business nor any of its controlling owners exercise authority over the management, business policies and operations of the business entity.

4. A controlled or controlling business entity will be deemed an “unrelated affiliate” (not an *affiliate*) if LED determines that the business entity is not engaged in any line of business related to the project activities.

#### *Beginning of the Project*—

1. the first day on which project foundations are started or where foundations are unnecessary, the first day on which installation of the project facility begins or the first day that materials or equipment purchased for the project are received;

2. where there is no construction, installation, or purchase of materials or equipment, the first day on which a new hire is made in connection with the project; or

3. the beginning date reported on the application (which date must be on or after the date the advance notification was filed).

#### *Board*—the Board of Commerce and Industry.

*Business*—a legal entity applying for the Enterprise Zone Program that conducts any activity carried on for the production of income from selling goods or performing services. A business may be conducted in the form of either a for-profit or not-for-profit entity. A not-for-profit entity will be considered a business only if it provides goods or services for a fee based upon the cost of providing those goods or services (for example, hospitals).

*Business Incentives Services*—the Business Incentive Services Division of the Office of Business Development of the department.

*Contract Effective Date*—the day that the advance notification and fee were received by Business Incentives Services or the beginning of the project shown on the application. The contract effective date cannot be earlier than the date the advance notification was received by Business Incentive Services unless a waiver of timely filing has been approved by the board.

*Department*—Louisiana Department of Economic Development.

*Department of Revenue*—Louisiana Department of Revenue.

*Domicile*—the place of a person's principal establishment or habitual residence. A change of domicile may be shown by positive and satisfactory proof of establishment of domicile as a matter of fact with the intention of remaining in the new place and of abandoning the former domicile. Such proof may include a sworn declaration of intent recorded in the parish to which a person intends to move, voter registration, or similar evidence of such intent.

*Economic Development Zone*—

1. a contiguous geographic area with a visible boundary, owned or operated by a political subdivision or an entity created by a political subdivision for commercial or industrial development purposes, including but not limited to the following:

- a. industrial park;
- b. business park;
- c. airport or air park;
- d. research park;
- e. research and development park;
- f. downtown development district with taxing and bonding authority;
- g. former federal facility (immediately prior owner and occupant must have been a federal governmental entity), excluding a single building or small grouping of buildings; or
- h. port.

2. An Economic Development Zone must be designated as such by the political subdivision in which it is located, and approved by the board. The location of an Economic Development Zone once defined is permanent, and cannot be moved or relocated.

*Employment Baseline*—

1. the baseline from which net new jobs are determined, equal to:

a. the median number of full time employees and part time employees of the business (including employees of affiliates, and employees of unrelated affiliates who have also been employed by the business within the 12 months prior to the contract effective date) at the project site, during the payroll periods including the twelfth day of the month, in the last four months completed prior to the contract effective date (the median is calculated by discarding the months with the highest and lowest number of employees, and averaging the number in the remaining two months); or

b. the last annual average number of full time employees and part time employees certified under an enterprise zone contract for the business that was in effect on the day prior to the contract effective date.

2. The baseline must be maintained in any year for which the business requests job tax credits.

3. For projects with advance notifications filed with Business Incentives Services prior to the effective date of the 2010 revision of these rules, employment baseline will be determined in accordance with prior policy and practice.

*Enterprise Zone*—a census block group which is economically distressed and in need of expansion of business and industry and the creation of jobs, and designated by the Board to be eligible for the benefits of this Chapter in accordance with R.S. 51:1784.

*Full Time Employee*—an employee who is reported on the business's quarterly report and is scheduled to work 35 hours per week.

*Headquarters*—the corporate domicile of the company, together with all executive and administrative jobs normally constituting a corporate headquarters, or the regional headquarters support services of the company, together with all executive and administrative jobs normally constituting a regional corporate headquarters.

*Hire Date*—the first day of work for which the business directly pays an employee.

*Lacking Basic Skills*—an employee who exhibits below a ninth grade level proficiency in reading or writing or math.

*Louisiana Workforce Commission*—formerly known as the Louisiana Department of Labor.

*NAICS*—North American Industrial Classification System.

*Net New Job*—

1. a position of employment that is:
  - a. created on or after the contract effective date;
  - b. in addition to the number of jobs in the employment baseline;
  - c. based at the site of the enterprise zone project;
  - d. filled by a full time employee or part time employee; who is
  - e. a United States citizen domiciled in Louisiana, or who becomes domiciled in Louisiana within 60 days after hire date; and who is
  - f. reported on the business's quarterly report.

2. The number of net new jobs filled by full time employees shall be determined by averaging the monthly totals of full time employees over a minimum of seven months for the first and last year of the contract period, and over a 12 month period for all other years. The number of net new jobs filled by part time employees shall be determined by counting the number of employees qualifying as part time employees during the applicable period.

3. For purposes of determining qualification of the business for the Enterprise Zone Program under §701.E, net new jobs shall be limited to permanent full-time jobs that are in addition to the number of permanent full-time jobs included in the employment baseline.

4. Jobs in which employees perform essentially the same work at the same location both before and after the contract effective date are not net new jobs unless:

- a. there has been an arm's length transfer of ownership between unrelated companies (not affiliates); and
- b. either the location has been out of operation for at least three months, or the secretary determines that the jobs would have likely been lost to the state absent the transfer.

5.a Transferred jobs which are not net new jobs include:

i. jobs transferred, or jobs associated with work or sales transferred to the project site from other Louisiana sites of the business (including affiliates), unless back-filled at the original site;

ii. jobs transferred, or jobs associated with work or sales transferred, to the business from affiliates and unrelated affiliates on the project site, unless back-filled;

iii. jobs transferred, or jobs associated with work or sales transferred, to the project site from other Louisiana sites as a result of the business (including affiliates) acquiring a business operation, or substantially all of its assets, and continuing the business operation;

b. jobs created for the project, but temporarily assigned to another site until the site is ready or for training or similar purposes, are not considered transferred jobs and may be considered net new jobs when re-assigned to the project site.

6. Lost jobs which must be deducted in determining net new jobs include:

a. jobs lost due to closure of any site of the business (including affiliates) that:

i. is located within the same parish; and

ii. provides the same goods or services as the project site;

b. jobs lost due to downsizing of any site of the business (including affiliates) that:

i. is located within the same parish; and

ii. provides the same goods or services as the project site;

iii. the project site and the other site each sell their goods or services primarily into that parish; and

iv. the downsizing was anticipated by the business at the time the Qualification Certification was filed;

c. jobs lost due to closure or downsizing of any site of the business (including affiliates) that:

i. is located in the state of Louisiana; and

ii. provides the same goods or services;

iii. primarily for the same market segment or customer base, as the project site; and

iv. the closure or downsizing was anticipated by the business at the time the Qualification Certification was filed;

d. jobs lost by the business (including affiliates) due to relocation outside Louisiana or downsizing of headquarters operations or headquarters support services of the business (including any intermediate or ultimate parent company), and the relocation or downsizing was anticipated by the business at the time the Qualification Certification was filed.

*Part Time Employee*—an employee who is reported on the business's quarterly report and works a minimum of 20 hours each week for at least 26 consecutive weeks during the taxable year.

*Permanent Job*—as established in the qualification certification (as of the time the qualification certification is filed and irrespective of subsequent modifications to the job), a job that has no anticipated end date falling within the period commencing 45 days prior to the contract effective date and ending five years after the contract effective date.

*Placed in Service*—the date indicated as *placed in service* on the business's federal tax return depreciation schedule.

*Political Subdivision*—in this Chapter, a state, parish, municipality or other political subdivisions, including and not limited to a law enforcement or other special district authorized by law to perform governmental functions.

*Project*—a construction, expansion, or other business venture and associated activities for which benefits are sought under the Enterprise Zone Program.

*Project Completion Report*—a report confirming the beginning of the project, the project ending date, and the benefits elected.

*Project Ending Date*—the date all construction and purchasing is completed and received for the project, completing the project.

*Project Period*—the time encompassed by the contract effective date and the project ending date.

*Project Site*—the contiguous physical location of a project.

*Qualified Expenditure*—amounts classified as capital expenditures for federal income tax purposes plus exclusions from capitalization provided for in Internal Revenue Code Section 263(a)(1)(A) through (L), minus the capitalized cost of land, capitalized leases of land, capitalized interest, capitalized costs of manufacturing machinery and equipment to the extent the capitalized manufacturing machinery and equipment costs are excluded from sales and use tax pursuant to R.S. 47:301(3), and the capitalized cost for the purchase of an existing building. When a taxpayer purchases an existing building and capital expenditures are used to rehabilitate the building, the costs of the rehabilitation only shall be considered qualified expenditures. Additionally, a taxpayer shall be allowed to increase their qualified expenditures to the extent a taxpayer's capitalized basis is properly reduced by claiming a federal credit.

*Quarterly Report*—the Quarterly Report of Wages Paid that a business files with the Louisiana Workforce Commission.

*Rural Enterprise Zone*—an enterprise zone located in a parish having a current U.S. Census population of 75,000 or less.

*Some Form of Public Assistance*—any program of assistance financed in whole or in part by a federal, state, or any local government agency, eligibility for which is dependent upon the employment status or income level of the individual. Any such assistance must have been received by the individual within a six-month period prior to their hire date. Unemployment is not public assistance.

*State*—state of Louisiana

*Unemployable by Traditional Standards*—having no prior work history or job training, having a criminal record (excluding misdemeanors), having a history of being unable to retain employment after gaining it, or being physically challenged.

*Urban Enterprise Zone*—an enterprise zone located in a parish having a current U.S. Census population greater than 75,000.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2299 (November 2003), amended LR 37:297 (January 2011).

#### **§705. Endorsement Resolution**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, Office of Commerce and Industry, LR 8:230 (May 1982), amended LR 9:544 (August 1983), amended by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, LR 11:95 (February 1985), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 17:253 (March 1991), amended by the Department of Economic Development, Office of Commerce and Industry, LR 22:447 (June 1996), amended by the Department of Economic Development, Office of Business Development, LR 29:2300 (November 2003), repealed LR 37:300 (January 2011).

#### **§707. Items Eligible for Sales and Use Tax Rebate**

A. Materials that are permanently installed at the project site during the project period are eligible for sales and use tax rebates.

B. Materials that originate from a contractor or subcontractor's inventory and are permanently installed at the project site during the project period are eligible for sales and use tax rebates. In order for rebates to be issued on property withdrawn from inventory, the contractor or subcontractor must maintain sufficient records and provide sufficient information to enable the Department of Revenue to verify that Louisiana sales or use taxes were paid on the property for which rebate is claimed.

C. Machinery and equipment purchased for the project during the project period are eligible for sales and use tax rebates provided that the machinery and equipment are used exclusively at the project site, are owned by an entity named in the enterprise zone contract, and are intended to remain at the project site for the expected useful life of the machinery and equipment.

D. Machinery and equipment transferred into Louisiana for the project during the project period are eligible for sales and use tax rebates provided that the machinery and equipment are used exclusively at the project site, are owned by an entity named in the enterprise zone contract, and are intended to remain at the project site for the expected useful life of the machinery and equipment.

E. Software purchased, capitalized, and used by the business primarily at the project site during the project period is eligible for sales and use tax rebates.

F. Consumable items are not eligible for sales and use tax rebate. Ineligible items include but are not limited to: per diem, labor, service contracts, storage, freight, radios, laptop computers, utilities, permits and fees, office supplies, construction consumables, blades, drill bits, PVC sheeting, tape, gloves, dusk masks, and all leases and rentals.

G. Lease-purchases may be eligible for a sales and use tax rebate upon Department of Revenue's approval. The property acquired through lease-purchase must be used exclusively at the project site, must be owned by an entity named in the enterprise zone contract, and must be intended to remain at the project site for the expected useful life of the machinery and equipment. A copy of the lease-purchase agreement must be submitted with the claim for rebate request to Department of Revenue, Office Audit Division.

H. A lease of an improvement to immovable property may be eligible for sales and use tax rebate upon the following conditions:

1. the improvements were made with the specific intent to enter into a lease agreement for the use of the improvements by the business, that is, an agreement to lease the improvements must exist before construction begins;

2. at its inception the lease must meet one or more of the following four criteria:

a. the lease transfers ownership of the property to the lessee by the end of the lease term;

b. the lease contains a bargain purchase option;

c. the lease term must be a minimum of twenty years;

d. the present value of the minimum lease payments, excluding any portion of the payments representing costs such as insurance, maintenance, and taxes to be paid by the lessor, equals or exceeds 90 percent of the fair value of the leased property; and

3. rebates shall be paid to the lessee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, LR 9:230 (May 1982), amended LR 9:544 (August 1983), LR 11:96 (February 1985), amended by the Department of Economic Development, Office of Business Development, LR 17:255, (March 1991), LR 22:449 (June 1996), LR 29:2302 (November 2003), LR 37:300 (January 2011).

#### **§709. Targeted Employees for a Business in an Urban Enterprise Zone**

A. A business located in an urban enterprise zone and receiving the benefits of this Chapter must certify that at least 35 percent of the employees filling net new jobs meet one of the following requirements:

1. resident in an enterprise zone in the state;

2. receiving some form of public assistance within the six-month period prior to their hire date;

3. lacking basic skills; or

4. unemployable by traditional standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, Office of Commerce and Industry, LR 8:230 (May 1982), amended LR 9:544 (August 1983), amended by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, LR 11:95 (February 1985), amended by the Department of Economic Development, Office of Commerce, Finance Division, LR 17:253 (March 1991), amended by the Department of Economic Development, Office of Commerce and Industry, LR 22:447 (June 1996), amended by the Department of Economic Development, Office of Business Development, LR 29:2300 (November 2003), LR 37:300 (January 2011).

#### **§711. Targeted Employees for a Business in a Rural Enterprise Zone**

A. A business located in a rural enterprise zone and receiving the benefits of this Chapter must certify that at least 35 percent of the employees filling net new jobs meet one of the following requirements:

1. resident of the same parish as the project site;

2. resident of an enterprise zone in the state;

3. receiving some form of public assistance within the six month period prior to their hire date;

4. lacking basic skills; or

5. unemployable by traditional standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Commerce, Office of Commerce and Industry, LR 8:230 (May 1982), amended LR 9:544 (August 1983), amended by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, LR 11:95 (February 1985), amended by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 17:254 (March 1991), amended by the Department of Economic Development, Office of Commerce and Industry, LR 22:448 (June 1996), amended by the Department of Economic Development, Office of Business Development, LR 29:2301 (November 2003), LR 37:300 (January 2011).

**§713. Targeted Employees for a Business in an Economic Development Zone**

A. A business located in an economic development zone and receiving the benefits of this Chapter must certify that at least 35 percent of the employees filling net new jobs meet one of the following requirements:

1. resident of the same parish as the project site;
2. resident of an enterprise zone in the state;
3. receiving some form of public assistance within the six month period prior to their hire date;
4. lacking basic skills; or
5. unemployable by traditional standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2301 (November 2003), amended LR 37:301 (January 2011).

**§715. Targeted Employees for a Business Not in an Enterprise Zone or Economic Development Zone**

A. A business not located in an enterprise zone or economic development zone and receiving the benefits of this Chapter must certify that at least 35 percent of the employees filling net new jobs meet one of the following requirements:

1. resident of an enterprise zone in the state;
2. receiving some form of public assistance within the six month period prior to their hire date;
3. lacking basic skills; or
4. unemployable by traditional standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2301 (November 2003), amended LR 37:301 (January 2011).

**§717. Annual Employee Certification**

A. An annual Employee Certification Report (ECR) must be filed with the Business Incentive Services by May 31 on all active contracts validating compliance with §§709, 711, 713, and 715. Failure to file may result in contract cancellation. One 30 day extension may be granted if requested in writing.

B. If the employee certification report substantiates that the business has not created the permanent full-time net new jobs required for qualification under §701.E.1, the board shall cancel the contract and the business shall refund all credits and rebates received. If not timely paid in compliance with the contract, the department will notify Department of

Revenue of the contract violation, and the business will be subject to the provisions of §737.

C. For projects with advance notifications filed with Business Incentive Services prior to the effective date of the 2010 revision of these rules, the annual employee certification process will be performed in accordance with prior policy and practice.

D. A business may request that its contract be terminated and that it no longer be required to file an ECR if:

1. the contract has been in effect for at least 30 months; and
2. the business has met all of the requirements of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2301 (November 2003), amended LR 37:301 (January 2011).

**§721. Advance Notification**

A. An Advance Notification form, and the required fee, shall be filed with Business Incentive Services prior to the beginning of the project. All incentives for the same project must be indicated on one advance notification and be identified by one project number. It is not acceptable to apply for Enterprise Zone Program and use the same project in a miscellaneous capital addition application for the Industrial Tax Exemption Program. Internet filing of the advance notification may be made at the department website.

B. An advance notification expires one year after the estimated project ending date shown on the advance notification, unless an application is timely filed, or a written date revision request is received by Business Incentive Services prior to the expiration date.

C. An advance notification filed after the beginning of the project requires a waiver of late filing from the board, based upon events beyond the control of the business caused the late filing or documented fault or error on the part of the business incentive services that caused the business's late filing. Lack of knowledge of the existence of the Enterprise Zone Program or its benefits or procedures will not be accepted as a valid reason for waiving the timely filing requirement. A waiver of late filing will allow the business to proceed as if the advance notification was filed timely.

D. A business proposing a project exceeding 30 months must separate the project into phases with no phase having a project period greater than 30 months. The business must comply with §701.E. qualifications, and file a separate advance notification, application, project completion report, and affidavit of final cost, with the required fees, for each phase of the project. The business must elect either the sales and use tax rebate or the investment tax credit for all phases of the project. Businesses electing the investment tax credit are not subject to the 50 percent limitation of §731.B. for phases subsequent to the initial phase, and may elect to file one investment tax credit claim for all consecutive project periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development LR 29:2302 (November 2003), amended LR 37:301 (January 2011).

### **§723. Application**

A. An application for an enterprise zone contract, and the required fee, must be filed with Business Incentives Services, on the form prescribed, within three months after the project ending date. Internet filing of the application may be made at the department's website. Upon request, the business shall receive a thirty day extension of time in which to file its application, provided such request for extension is received by Business Incentives Services no later than the filing deadline date.

B. With or after the filing of the advance notification, but no later than with the filing of the application, the business shall file with Business Incentives Services, on the form prescribed, a qualification certification of the intended number of permanent full-time net new jobs for purposes of determining eligibility for the Enterprise Zone Program.

C. An application fee equal to 0.2 percent (0.002) of the total estimated tax relief shall be submitted with each application. Total estimated tax relief includes jobs tax credits, state sales and use tax rebates and investment tax credits. Jobs tax credits are calculated by multiplying the total new jobs estimated to be created within the five-year contract period by \$2,500 (\$5,000 for rubber, aerospace or auto parts manufacturers). An additional application fee will be due if a project's employment or investment is increased from that stated in the application, resulting in a minimum fee of \$100 more than previously paid. The minimum fee is \$200 and the maximum fee is \$5,000 per application. All fees shall be made payable to: Louisiana Department of Economic Development.

D. An application must be submitted to Business Incentive Services at least 45 days prior to the board meeting where it is intended to be presented for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development LR 29:2302 (November 2003), amended LR 37:302 (January 2011).

### **§725. Recommendations of the Secretaries of Economic Development and Revenue**

A. Business Incentive Services shall forward the application with its recommendation to the secretary of the Louisiana Department of Revenue and the secretary of the Louisiana Department of Economic Development for their review and recommendations. The secretaries of the Department of Revenue and the department may submit a letter of no objection in lieu of a letter of recommendation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2303 (November 2003), amended LR 37:302 (January 2011).

### **§727. Application Review by the Board of Commerce and Industry**

A. Business Incentive Services shall present an agenda of applications to the board with recommendations based upon its findings.

B. Each business or its representative will be notified of the board meeting date at which its application will be considered. The business should have someone present who is able to answer any questions the board may have regarding the information contained in the application. In the

event there is no representative present, the application may be deferred or denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2303 (November 2003), amended LR 37:302 (January 2011).

### **§729. Enterprise Zone Program Contract**

A. Upon approval of the application, the board shall enter into a contract with the business for the benefits allowed by this Chapter. The business must execute its portion of the contract and return it to Business Incentive Services within 60 days. If the contract is not returned within 60 days, the board may rescind the approval of the application. When the contract has been fully executed, an original contract will be returned to the business. An original will be sent to the Department of Revenue and, if applicable, a copy sent to the political subdivision.

B. Business Incentive Services must be notified, on the prescribed form, of any change that will affect the contract. This includes, but is not limited to, changes in the ownership or operational name of the business holding a contract, or the suspension, closing, or abandonment of operations. Failure to report any changes within six months may constitute a breach of contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2303 (November 2003), amended LR 37:302 (January 2011).

### **§731. Project Completion**

A. Within six months after the project ending date or the governor's signature on the contract, whichever is later, the business shall file with Business Incentive Services, on the prescribed form, a project completion report and an affidavit of final cost, with the required inspection and audit fee.

B. The project completion report shall confirm the beginning of the project, the project ending date, and the incentive benefits elected. Local sales and use tax rebate is not available if the investment tax credit is elected. Except as provided in Section 721.D, the investment tax credit may not be elected if more than 50 percent of the qualified expenditures related to the project (including intangible costs such as architectural and/or engineering fees prior to construction) are incurred before the filing of the advance notification.

C. The affidavit of final cost shall list all eligible purchases and qualified expenditures for the project, with a description of the buildings, equipment, or other assets, and the cost of each item.

D. After completion of the project and the governor's signature of the contract, the department shall sign the project completion report and forward copies to the business, the Department of Revenue, and any political subdivision rebating local sales and use tax.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2303 (November 2003), amended LR 37:302 (January 2011).

### **§732. Investment Tax Credit Claims**

A. The investment tax credit is earned in the year in which the project is placed in service, and is based upon all

qualified capitalized expenditures related to the project as of the date it is placed in service, regardless of whether the actual time period involved exceeds 30 months.

B. The investment tax credit claim must be filed with the Department of Revenue, Office Audit Division, with the required documentation.

C. The investment tax credit may be taken on qualified expenditures that are related to the project and are placed in service during the project period. The investment tax credit applies to the assets that are related to the qualified expenditures, provided that the business reasonably intends for such assets to remain at the project site for their expected useful life. The assets may be recorded on the financial statements of a company that is an affiliate of the business.

D. The claim for investment tax credit must be filed with the Department of Revenue no later than six months after the Governor's signature of the contract and the department's signature of the project completion report, and must be accompanied by the signed Project Completion Report. Upon request, the business shall receive a 30 day extension of time in which to file its claim, provided such request for extension is received by the Department of Revenue prior to the expiration of such filing period. The Department of Revenue is also authorized to grant the business an additional extension of time, not to exceed 60 days, in which to file its claim provided that the business shows reasonable cause for granting such extension.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 37:302 (January 2011).

### **§733. Sales and Use Tax Rebate Requests**

A. The Enterprise Zone Program contract will not authorize the business to make tax exempt purchases from vendors. The Department of Revenue will advise the business on the proper procedures to obtain the state sales and use tax rebate. The request for rebate of sales and use taxes must be made by filing a claim with the Department of Revenue, Office Audit Division, and must include the following:

1. list of eligible purchases, including a brief description of each item, the vendor's name, date of the delivery, sales price and the amount of state sales and use tax paid. The listed items must have been purchased by the business, or by a builder, a contractor, or other party that contracted with the owner to provide materials, equipment, machinery, or software that is used by the business at the project site or is listed in the Enterprise Zone Program contract;

2. certification that the listed materials are reasonably expected to qualify for a rebate under the Enterprise Zone Program; and

3. certification that state sales and use taxes have been paid on the listed items.

B. The request may be filed on the official Department of Revenue "claim for rebate" form or on other forms prepared by the business. After the Department of Revenue has validated the information on the claim for rebate, a rebate check will be issued for the amount of substantiated state sales and use taxes paid.

C. The request for rebate must be filed with the Louisiana Department of Revenue, and the political subdivision rebating local sales and use tax, no later than six months after the Department of Economic Development signs a project completion report and sends it to the Department of Revenue, the political subdivision, and the business, or no later than 30 days after the end of the calendar year in the case of customer-owned tooling used in a compression molding process and must be accompanied by the signed Project Completion Report. Upon request, the business shall receive a 30 day extension of time in which to file its claim, provided such request for extension is received by the Department of Revenue prior to the expiration of such filing period. The Department of Revenue is also authorized to grant the business an additional extension of time, not to exceed 60 days, in which to file its claim, provided that the business shows reasonable cause for granting such extension.

D. The business should contact the political subdivision issuing the endorsement resolution to determine the procedure for local sales and use tax rebate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2303 (November 2003), amended LR 37:303 (January 2011).

### **§735. Business with a Contract Must File State Income and Franchise Tax Returns**

A. Businesses that have satisfied their Louisiana income tax and/or franchise tax liability by applying jobs tax credits earned under this Chapter shall file the same forms and tax returns with the Department of Revenue that are required if no jobs tax credit were claimed. Each annual return on which jobs tax credits are taken must have a copy of the letter from Business Incentive Services certifying the jobs tax credits earned. If total jobs tax credits are less than the total taxes, remittance in the amount of the difference must be enclosed with the tax return. Limited Liability Companies, Sub Chapter S Corporations, etc., must have the name(s) of owners and their Social Security numbers or Department of Revenue number for corporations listed on the contract in order for jobs tax credits to flow through to the owner(s).

B. Partnerships and sole proprietorships shall file the same returns that are required if the jobs tax credits were claimed. Each annual return on which jobs tax credits are taken must have a copy of the letter from Business Incentives Services certifying the tax credits earned. If total jobs tax credits are less than the total taxes, remittance in the amount of the difference must be enclosed with the tax return.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2304 (November 2003), amended LR 37:303 (January 2011).

### **§737. Violation; Cancellation of Contract**

A. On the initiative of the board upon notice or a written complaint of violation of the terms of the statutes, rules or the contract, the board or its representative shall determine if a full investigation should be made. The board shall have full authority for such investigation, including but not

exclusively, the authority to call for reports, pertinent records, or other information from the business. If the investigation appears to substantiate a violation the board or its representative will present the subject contract for formal action.

B. If a business is found to be in violation of the statutes, these rules or the contract, board may cancel the contract and the business shall remit back to the state all jobs tax credits taken on income tax and franchise returns, all state and local sales and use tax rebates, Investment Tax Credit, and any other taxes that would have been imposed but for the issuance of this contract.

C. The department shall notify the Department of Revenue of the cancellation, and the Department of Revenue will proceed by all appropriate means to recapture all benefits received pursuant to this Chapter, including any penalty and interest due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2304 (November 2003), amended LR 37:303 (January 2011).

#### **§739. Fees**

A. Advance notifications, applications, and Affidavits of Final Cost are not considered filed without payment of the proper fee, and Business Incentives Services may return the filing to the business if the estimated tax relief or the fee submitted is incorrect. An application or Affidavit of Final Cost may be resubmitted within 30 days with the correct fee without penalty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2304 (November 2003), amended LR 37:304 (January 2011).

#### **§743. Relocation of Enterprise Zones**

A. A municipality or parish requesting the relocation of an Enterprise Zone must provide valid reason for requesting the move and must have the approval of the board.

B. The residents of originally designated Enterprise Zone may qualify as part of the 35 percent residency requirement.

C. The effective date of a relocation approved by the Board shall be the date of passage affixed to the resolution by the local governing authority requesting the relocation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2304 (November 2003), amended LR 37:304 (January 2011).

#### **§745. Appeals**

A. A business may appeal an action of the Board by submitting its appeal along with any necessary documentation to Business Incentives Services no later than 90 days after the board action. The appeal shall not be considered by the board less than 30 days after submission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development, LR 29:2304 (November 2003), amended LR 37:304 (January 2011).

#### **§749. Prohibit Local Fees and Prohibit Local Conflicting Employment Practices**

A. No political subdivision shall charge any fees or require any employment practices which conflict with state

law as a precondition to authorize tax benefits under this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1786(5).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, Finance Division, LR 17:257 (March 1991), amended by the Department of Economic Development, Office of Commerce and Industry, LR 22:451 (June 1996), amended by the Department of Economic Development, Office of Business Development, LR 29:2305 (November 2003), LR 37:304 (January 2011).

Kristy G. McKearn  
UnderSecretary

1101#089

### **RULE**

#### **Department of Economic Development Office of Business Development**

#### **Industrial Ad Valorem Tax Exemption Program (LAC 13:I.Chapter 5)**

The Department of Economic Development, Office of Business Development, as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., hereby repeals Sections 501 and 539 through 565, and amends and reenacts Rules 502 through 507 of the Industrial Ad Valorem Tax Exemption Program as LAC 13:I.Chapter 5.

### **Title 13**

#### **ECONOMIC DEVELOPMENT**

#### **Part I. Financial Incentive Programs**

#### **Chapter 5. Industrial Ad Valorem Tax Exemption Program**

#### **§501. Use of Louisiana Contractors, Labor and Supplies**

Repealed.

AUTHORITY NOTE: Adopted in accordance with R.S. 51:921 et seq.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:304 (January 2011).

#### **§503. Advance Notification; Application**

A. An advance notification of intent to apply for tax exemption shall be filed with the LED Office of Business Development (OBD) on the prescribed form prior to the beginning of construction or installation of facilities. The phrase "beginning of construction" shall mean the first day on which foundations are started, or, where foundations are unnecessary, the first day on which installation of the facility begins. An advance notification fee of \$100 shall be submitted with the form. The advance notification will expire and become void if no application is filed within 12 months of the estimated project ending date stated in the advance notification (subject to amendment by the applicant).

B. Except as otherwise provided for miscellaneous capital additions under §505, an application for tax exemption may be filed with OBD on the prescribed form:

1. either concurrent with or after filing the advance notification, but no later than 90 days after the beginning of operations or end of construction, whichever occurs first;

2. the deadline for filing the application may be extended pursuant to §523;

3. an applicant filing an application prior to the beginning of operations or end of construction of the project shall file an annual status report with OBD on the prescribed form by December 31, until the Project Completion Report and Affidavit of Final Cost are filed. If the applicant fails to timely file a status report the board may, after notice to the applicant, terminate the contract.

C. An application fee shall be submitted with the application in the amount equal to 0.2 percent of the estimated total amount of taxes to be exempted. In no case shall an application fee be smaller than \$200 and in no case shall a fee exceed \$5,000 per project.

D. OBD reserves the right to return the advance notification, application, or Affidavit of Final Cost to the applicant if the form is incomplete or incorrect. or the correct fee is not submitted. The document may be resubmitted with the correct information and fee.

E. If the application is submitted after the filing deadline, the ten year term of exemption available under an initial contract and renewal thereof may be reduced by one year for each year or portion thereof that the application is late, up to a maximum reduction of five years. The board may impose any other penalty for late filing that it deems appropriate.

F. Eligibility of the applicant and the property for the exemption will be reviewed by the board based upon the facts and circumstances existing at the time the application is considered. The property exempted may be increased or decreased based upon review of the application, Project Completion Report or Affidavit of Final Cost. An application filed prior to completion of construction may be considered by the board and a contract may be executed based upon the best available estimates, subject to review and approval of the Project Completion Report and Affidavit of Final Cost. If the applicant fails to timely file the Project Completion Report or Affidavit of Final Cost the board may, after notice to the applicant, terminate the contract.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by Department of Commerce, Office of Commerce and Industry, LR 11:97 (February 1985), LR 12:662 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, LR 20:864 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:304 (January 2011).

#### **§505. Miscellaneous Capital Additions**

A. Miscellaneous capital additions (MCA) is an accumulation of capital assets placed in service during the previous ad valorem tax year. An MCA must be part of a project that is completed within an 18 month period, and may not exceed \$5,000,000.

##### **B. MCA Applications**

1. For property in parishes other than Orleans Parish, MCA Applications for tax exemption shall be filed with OBD on the prescribed form not later than March 31 of each year, listing and clearly documenting the nature, date and

amount of miscellaneous capital additions placed in service during the preceding calendar year, and deducting therefrom the original cost of any replacements made.

2. For property in Orleans Parish, MCA applications for tax exemption shall be filed with OBD on the prescribed form not later than October 31, listing and clearly documenting the nature, the date and the amount of miscellaneous capital additions placed in service since August 1 of the preceding year, and deducting therefrom the original cost of any replacements made.

C. An application fee shall be submitted with the MCA application in the amount equal to 0.2 percent of the estimated total amount of taxes to be exempted. In no case shall an application fee be smaller than \$200 and in no case shall a fee exceed \$5,000 per project.

D. OBD reserves the right to return the application to the applicant if the form is incomplete or incorrect. or the correct fee is not submitted. The document may be resubmitted with the correct information and fee.

E. If the application is submitted after the filing deadline, the ten year term of the exemption available under an initial contract and renewal thereof shall be reduced by one year for each month or portion thereof that the application is late, up to a maximum reduction of five years. The board may impose any other penalty for late filing that it deems appropriate.

F. Eligibility of the applicant and the property for the exemption will be reviewed by the Board based upon the facts and circumstances existing at the time the application is considered. The property exempted may be increased or decreased based upon review of the application.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Office of Commerce and Industry, LR 11:97 (February 1985), amended LR 12:662 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, LR 20:865 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:305 (January 2011).

#### **§507. Manufacturing Establishment Clarified**

A. The terms *manufacturing establishment* and *addition* as used herein mean a new plant or establishment or an addition or additions to any existing plant or establishment which engage in the business of working raw materials into wares suitable for use or which give new shapes, qualities, or combinations to matter which already has gone through some artificial process.

B. The board shall consider for tax exemption buildings and facilities used in the operation of new manufacturing establishments located within the state of Louisiana (subject to the limitations stated in §517 and 519) and additions for existing manufacturing establishments within the state of Louisiana. Exemptions are granted to the owners of buildings that house a manufacturing operation and facilities that are operated specifically in the manufacturing of a product. The board recognizes two categories of ownership:

1. owners who engage in manufacturing at said facilities; and

2. owners who are not engaged in manufacturing at said manufacturing establishment, but who have provided either or both of the following for a predetermined manufacturing establishment:

a. buildings to house a manufacturing establishment;

b. facilities that consist of manufacturing equipment operated specifically in the manufacturing process.

C. Leased property is eligible for the exemption, if the property is used in the manufacturing process, remains on the plant site, and the manufacturer is obligated under the lease agreement to pay the property taxes if the exemption were not granted.

D. Capitalized materials which are an essential and integral part of a manufacturing process, but do not form part of the finished product, may be exempted along with the manufacturing facility. Some examples of these are:

1. ammonia in a freezing plant;
2. solvent in an extraction plant; and
3. catalyst in a manufacturing process.

E. To be eligible for exemption, a manufacturing establishment must be in an operational status, engaged in the business of producing or processing goods. An owner of a new facility under construction may apply for an exemption with the expectation that the facility will become operational. If the manufacturing establishment fails to become operational or ceases operations without a reasonable expectation of recommencing operations, the facility may no longer be eligible for exemption and its contract may be subject to termination under Section 531.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:865 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:305 (January 2011).

#### **§509. Office Furniture and Fixtures; Portable Equipment**

A. Office furniture and fixtures are eligible for tax exemption only when they are an integral part of the manufacturing operation and permanently located at the manufacturing establishment.

B. Portable equipment is subject to exemption if it is not removed from the exempted property and is necessary to the continued maintenance or operation of the manufacturing process. Such property, therefore, is not to be rented, leased or used outside facility boundaries.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:306 (January 2011).

#### **§511. Replacement Property**

A. Capital additions for remodeling an existing manufacturing facility may be exempted. If replacements are made, only the capital expenditures in excess of original cost shall be eligible for tax exemption. A deduction for the original cost of property to be replaced shall not be made if the project will result in capital additions that exceed \$50,000,000.

B. Exemption may be granted on the costs of rebuilding a partially or completely damaged facility, but only on the amount in excess of the original cost.

C. Original costs deducted from replacements made or rebuilding shall be clearly documented.

D.1. A deduction for the original cost of property to be replaced, as provided by Subsections A or B, shall not be made if the project is related to the replacement or reconstruction of property after the destruction of or damage to such property, as a result of a qualified disaster.

2. For purposes of this Subsection, the term “qualified disaster” means:

a. a disaster which results from:

i. an act of terror directed against the United States or any of its allies; or

ii. any military action involving the Armed Forces of the United States and resulting from violence or aggression against the United States or any of its allies (or threat thereof), but not including training exercises;

b. any disaster which, with respect to the area in which the property is located, resulted in a subsequent determination by the President of the United States that such area warrants assistance by the federal government under the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

c. a disaster which is determined by an applicable federal, state, or local authority (as determined by the secretary) to warrant assistance from the federal, state, or local government or agency or instrumentality thereof.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:306 (January 2011).

#### **§513. Relocations**

A. A manufacturing establishment moved from one location in the state to another place within the state shall be eligible for the unexpired consecutive years, if any, of the tax exemption contract granted the original location. Exemption may be granted at the new location on those costs of necessary replacements which are in excess of the original cost at the prior facility.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 29:2633 (December 2003), LR 37:306 (January 2011).

#### **§515. Used Equipment**

A. Used equipment is eligible for tax exemption provided no ad valorem property taxes have been paid in Louisiana on said property.

AUTHORITY NOTE: Promulgated in accordance with Article VD, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:886 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:306 (January 2011).

#### **§517. Assessed Property**

A. The board shall not consider for tax exemption any manufacturing establishment or addition thereto once such

establishment or addition has been in operation for a period of six months, unless the assessor of the parish in which the establishment or addition is located certifies in writing that said establishment or addition is not on the taxable rolls. If the establishment or addition is on the taxable rolls the board shall consider granting tax exemption only if the assessor agrees in writing to remove the establishment or addition from the taxable rolls should the tax exemption be granted.

B. The board shall not consider for tax exemption any property listed on an application on which ad valorem property taxes have been paid.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Commerce, Office of Commerce and Industry, LR 11:97 (February 1985), amended by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:306 (January 2011).

#### **§519. Land**

A. The land on which a manufacturing establishment is located is not eligible for tax exemption.

AUTHORITY NOTE: Promulgated in accordance with Article VU, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§521. Inventories**

A. The following are not eligible for tax exemption:

1. inventories of raw materials used in the course of manufacturing;
2. inventories of work-in-progress or finished products;
3. any other consumable items.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:866 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§523. Extension of Time**

A. OBD may grant an extension of up to six months for the filing of an application (§503.B.), a Project Completion Report (§525), or an Affidavit of Final Cost (§527), provided the request for extension is received prior to the filing deadline.

B. Additional extensions of time may be granted for good cause.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§525. Effective Date of Contract; Project Completion Report**

A. The owner of a new manufacturing establishment or addition shall document the beginning date of operations and the date that construction is substantially complete. The owner must file that information with OBD on the prescribed Project Completion Report form not later than 90 days after the beginning of operations, completion of construction, or receipt of the fully executed contract, whichever occurs last. The deadline for filing the Project Completion Report may be extended pursuant to §523.

B. The effective date of tax exemption contracts for property located in parishes other than Orleans Parish shall be December 31 of the year in which effective operation began or construction was essentially completed, whichever occurs first. The effective date of tax exemption contracts for property located in Orleans Parish shall be July 31 of the applicable year.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§527. Affidavit of Final Cost**

A. Within six months of the beginning of operations, completion of construction, or receipt of the executed contract, whichever occurs last, the owner of a manufacturing establishment or addition shall file on the prescribed form an Affidavit of Final Cost showing complete cost of the exempted project. A fee of \$100 shall be filed with the Affidavit of Final Cost. Upon request by OBD, a map showing the location of all facilities exempted in the project shall be submitted in order that the exempted property may be clearly identifiable. The deadline for filing the Affidavit of Final Cost may be extended pursuant to §523.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Commerce, Office of Commerce and Industry, LR 12:662 (October 1986), amended by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§529. Renewal of Tax Exemption Contract**

A. Application for renewal of the exemption must be filed with OBD on the prescribed form not more than six months before, and not later than, the expiration of the initial contract. A fee of \$50 shall be filed with the renewal application. The document shall not be considered officially received and accepted until the appropriate fee is submitted. Upon proper showing of full compliance with the initial contract of exemption, the contract may be approved by the board for an additional period of up to but not exceeding five years.

B. Eligibility of the applicant and the property for renewal of the exemption will be reviewed by the Board using the same criteria that was used for the initial contract, and based upon the facts and circumstances existing at the time the renewal application is considered. The property exempted for the renewal period may be increased or decreased based upon review of the renewal application. The term of the renewal contract may be reduced by one year for each calendar month, or portion thereof, that the renewal application is filed late. The board may impose any other penalty for late renewal submission that it deems appropriate.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:307 (January 2011).

#### **§531. Violation of Rules or Documents, Final Inspection**

A. The board reserves the right, on its own initiative or upon written complaint of an alleged violation of terms of tax exemption rules or documents, to conduct a final inspection. During the final inspection OBD may cause to be made a full investigation on behalf of the board and shall have full authority for such investigation including authority to demand reports or pertinent records and information from the applicant and complainants. Results of the investigation will be presented to the board.

B. All contracts of exemption shall be subject to the final inspection. If a final inspection indicates that the applicant has violated any terms of the contract or rules, or that the exempt facility is not engaged in manufacturing, the board may conduct a hearing to reconsider the contract of exemption, after giving the applicant not less than 60 days notice.

C. If the board determines that there has been a violation of the terms of the contract or the rules, that the property exempted by the contract is not eligible because it is not used in a manufacturing process, or that the facility has not commenced or has ceased manufacturing operations, the board may terminate or otherwise modify the contract.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the State Board of Commerce and Industry, December 9, 1946, amended and promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§533. Reporting Requirements for Changes in Operations**

A. OBD is to be notified immediately of any change which affects the tax exemption contract. This includes any changes in the ownership or operational name of a firm holding a tax exemption contract. The board may consider restrictions or cancellation of a contract for cessation of the manufacturing operation, or retirement of any portion of the exempted equipment. Failure to report any material changes constitutes a breach of contract and, with approval by the board, shall result in restriction or termination.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:867 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§535. Sale or Transfer of Exempted Manufacturing Establishment**

A. In the event an applicant should sell or otherwise dispose of property covered by a contract of exemption, the purchaser of the said plant or property may, within three months of the date of such act of sale, apply to the board for a transfer of the contract. The board shall consider all such applications for transfer of contracts of exemption strictly on the merits of the application for such transfer. No such transfer shall in any way impair or amend any of the provisions of the contract so transferred other than to change the name of the contracting applicant. Failure to request or apply for a transfer within the stipulated time period shall constitute a violation of the contract.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, LR 20:868 (August 1994), amended by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§537. Reporting to the Parish Assessor**

A. The applicant shall file annually with the assessor of the parish in which the manufacturing establishment is located, a complete taxpayer's report on forms approved by the Louisiana Tax Commission, in order that the exempted property may be separately listed on the assessment rolls.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, amended by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§539. Manufacturing Establishment Clarified**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§541. Office Furniture and Fixtures**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

#### **§543. Portable Equipment**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of

Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:308 (January 2011).

**§545. Relocated Plants**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, amended by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§547. Secondhand Items**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§549. Assessed Property**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§551. Land**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§553. Inventories**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§555. Extension of Time**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§557. Effective Date of Contract**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by

the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§559. Affidavit of Final Cost**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§561. Renewal of Tax Exemption Contract**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§563. Violation of Rules or Documents**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

**§565. Changes in Tax Exemption Contract**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with Article VII, Part 2, Section 21(F) of the Louisiana Constitution of 1974.

HISTORICAL NOTE: Adopted by the Department of Commerce, Office of Commerce and Industry, Division of Financial Programs Administration, September 1974, amended by the Department of Commerce, Office of Commerce and Industry, 12:663 (October 1986), repealed by the Department of Economic Development, Office of Business Development, LR 37:309 (January 2011).

Kristy G. McKearn  
Undersecretary

1101#090

**RULE**

**Department of Economic Development  
Office of Business Development  
Office of Entertainment Industry Development**

Sound Recording Production and Infrastructure  
Tax Credit Programs (LAC 61:I.1637)

The Department of Economic Development, Office of Business Development, Office of Entertainment Industries Development, as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and in accordance with R.S. 47:6023, hereby amends the following rules and regulations relative to its Sound Recording Tax Credit Program.

**Title 61**  
**REVENUE AND TAXATION**  
**Part I. Taxes Collected and Administered by the**  
**Secretary of Revenue**  
**Chapter 16. Louisiana Entertainment Industry Tax**  
**Credit Programs**  
**Subchapter C. Louisiana Sound Recording Investor Tax**  
**Credit Program**

**§1637. Certification**

- A. - A.3.b. ...
- \* \* \*
- B. Repealed.
- C. - C.1. ...

a. **Incorrect Reporting.** If an applicant submits a cost report required by the provisions of this Chapter and the report made and filed contains material misstatements, including but not limited to misrepresentation in or intentional omission from the cost report of events, transactions, or other significant information there may be cause for an additional audit.

b. **Related Party Transactions.** If an audit contains related party transactions in excess of 20 percent of the base investment there may be cause for an additional audit.

c. **Reimbursement of Audit Costs.** The department may undertake additional audit at the applicant's expense, to be performed by a state certified public accountant also certified in financial forensics or also certified as a fraud examiner. Audit fees will be assessed at the department's contracted fee, with a minimum of \$2,000 and a maximum of \$15,000 fee per audit.

- 2. - 6.c. ...

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 47:6023.

**HISTORICAL NOTE:** Promulgated by the Department of Economic Development, Office of Business Development, and the Department of Revenue, LR 34:1348 (July 2008), amended by the Department of Economic Development, Office of Business Development, Office of Entertainment Industry Development, LR 36:305 (February 2010), LR 37:310 (January 2011).

Kristy Mc Kearn  
Undersecretary

1101#051

**RULE**

**Board of Elementary and Secondary Education**

Bulletin 129—The Recovery School District  
(LAC 28:CXLV.1305.Chapters 1 and 11)

In accordance with R.S. 49:950, et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education has adopted *Bulletin 129—The Recovery School District*: Chapters 1 and 11. The policy aligns the Recovery School District with Bulletin 741, Louisiana Handbook for School Administrators, and outlines the fiscal and internal management of the Recovery School District.

Chapter 1 largely defines that the State Superintendent is to serve as the Recovery School District's governing authority, consistent with the authority delegated to the State Superintendent by the Board of Elementary and Secondary

Education (BESE). The Recovery School District Committee of BESE shall serve as the BESE lead group for oversight of the Recovery School District. The Bulletin provides that the Superintendent can make recommendations to BESE for the approval of charter schools. Chapter 1 also provides for the qualifications of the Recovery School District Superintendent who reports to the State Superintendent. Chapter 1 also states that the Recovery School district will also be subject to the policies contained in BESE Bulletin 741.

Chapter 11 deals with the fiscal management of the Recovery School District. Chapter 11 specifies that the Recovery School District shall have a BESE approved budget, prepare financial statements, be audited by the Office of Legislative Auditors, receive and use Minimum Foundation Program funds, and procure goods, services and contracts following the state guidelines.

**Title 28**  
**EDUCATION**

**Part CXLV. Bulletin 129—The Recovery School District**  
**Chapter 1. General Provisions**

**§101. Purpose**

A. The purpose of this policy bulletin is to set forth the role, responsibilities, and functions of the Recovery School District (RSD).

**AUTHORITY NOTE:** Promulgated in accordance with La. Const. Art. VIII, §3; R.S. 17:6(A)(10); R.S. 17:10.5.A.(1); R.S. 17:10.5.A.(2); R.S. 17:10.7.A.(1); and R.S. 17:1990.A.(2).

**HISTORICAL NOTE:** Promulgated by the Board of Elementary and Secondary Education, LR 37:310 (January 2011).

**Chapter 11. Fiscal Management**

**§1101. Fiscal Management Priorities**

A. The RSD shall manage the finances to provide the best educational opportunity to all students and in the manner most likely to bring the school to an acceptable level of performance.

B. The RSD must identify and explain financial priorities for schools that have been placed into the RSD. These priorities shall aim to improve the overall performance and efficiency of a school. These priorities may be altered in the annual budget reports to BESE.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), R.S. 17:1990.A.(2), R.S. 17:10.5.B, and R.S. 17:10.7.B.(1).

**HISTORICAL NOTE:** Promulgated by the Board of Elementary and Secondary Education, LR 37:310 (January 2011).

**§1103. Annual Budget**

A. BESE is the entity that makes the allocations of state, local, and federal funds to the RSD. If different funding amounts are allocated to different students, the funding shall follow the student.

B. The RSD's budget must be approved by BESE. The RSD shall present a proposed operational budget to BESE for review in May and for approval in June of each year. The RSD direct-operated and charter-operated schools shall budget on a fiscal year basis, July 1 through June 30.

C. The revenues/receipts and expenditures/disbursements in the RSD's budget shall be listed and classified in such manner and substance as prescribed by the Division of Administration.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), and R.S. 17:1990.A.(2).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:310 (January 2011).

**§1105. Budget Planning, Preparation, and Schedules**

A. The RSD shall present a proposed operational budget to BESE for review in May and for approval in June of each year.

B. The RSD must comply with all accounting principles prescribed by the commissioner of administration under R.S. 39:78.A.

C. The RSD superintendent shall make such annual financial reports to the State Department of Education by September 30 of each year as the state superintendent may require.

D. It shall be the responsibility of the RSD to submit to the State Department of Education in a timely manner all necessary and required information for the computation of an individual allocation from the minimum foundation formula. This information shall be submitted to the department in the form required by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), and R.S. 17:1990.A.(2).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:311 (January 2011).

**§1107. Budget and Other Financial Reporting**

A. RSD shall conform to all requirements in this Chapter in addition to all applicable state and federal statutes and policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), R.S. 17:1990.A.(2), and R.S. 39:78.A.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:311 (January 2011).

**§1109. Auditing**

A. The RSD shall submit to an audit of its operations. This audit shall be conducted in accordance with provisions and timelines established by the Office of the Legislative Auditor.

B. Upon transfer of a failing school to the RSD, the RSD shall utilize the results of any audit of the school that occurred before the transfer. The RSD shall continue implementing all corrective post-audit actions of the prior LEA as part of the RSD's own modification of the school's financial practices to improve those practices.

C. Once the Office of the Legislative Auditor has issued a report on the operations of the RSD, it shall be the responsibility of the department to provide BESE with a complete analysis of the report and to recommend corrective actions to be taken, when necessary.

D. The RSD shall comply with BESE's annually approved audit plan for the operations of the Bureau of Internal Audit (BIA) within the State Department of Education, as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), R.S. 17:1990.A.(2), R.S. 10.6.E, R.S. 24:513, and R.S. 17:3996(F).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:311 (January 2011).

**§1111. Allocation of Funds**

A. The state shall annually appropriate sufficient monies to fund any school in the RSD in an amount equal to, but not less than, the school's student membership count times 100 percent of the state share per student as provided in the MFP approved formula for the city, parish, or other local public

school system in which each school placed under the jurisdiction of the RSD is located as contained in the MFP budget letter approved by BESE. The appropriation shall be made to the administering agency for the RSD (the Louisiana Department of Education) and may be expended by the agency for the provision of services to students in the district.

1. No public monies shall be used to discriminate against protected classes or have the effect of discriminating in providing and ensuring equal education opportunities in Louisiana.

B. In addition to the appropriation required in Subsection A above, any city, parish, or other local public school board which had jurisdiction of a school prior to its transfer to the RSD shall annually allocate and transfer to the RSD an amount of money. That amount shall equal to the number of students enrolled in such a school times the local per pupil amount received by the school system from all of the following sources as provided in the Minimum Foundation Program approved formula, excluding any portion which has been specifically dedicated by the legislature or by voter approval to capital outlay or debt service or which was actually expended by the school board for facilities acquisition and construction as reported to the state Department of Education:

1. sales and use taxes, less any tax collection fee paid by the school system;

2. ad valorem taxes, less any tax collection fee paid by the school system; and

3. earnings from sixteenth section lands owned by the school system.

C. Such allocation and transfer shall be accomplished by a reduction in the amount of state funds otherwise to be allocated to the city, parish, or other local public school system as contained in the Minimum Foundation Program budget letter approved by BESE equal to the amount provided in this Section of this bulletin. Such reduction shall be allocated to the RSD.

D. In the case that there are insufficient funds available to provide the total due the RSD under this section of this bulletin if all state funds are reduced and allocated to the RSD, the prior system shall transfer to the RSD a sufficient amount of money remaining from the sources provided in Paragraphs B.1 through B.3 of this Section. In the case that the prior system's local revenues are insufficient to allow for the allocation to the RSD and to allow the prior system to maintain a minimum balance of 10 percent of state Minimum Foundation Program funding and 10 percent of the local revenues listed in Paragraphs B.1 through B.3 of this Section, local revenues otherwise required to be allocated to the RSD shall be reduced to an amount necessary to allow the prior system to maintain such balances. Such maintained minimum balances shall be applied firstly to the prior system's retiree health insurance costs and secondly to the prior system's board administrative costs.

E. In addition to the appropriation required in Subsection A above, any public entity other than a city, parish, or other local public school board which had jurisdiction of a school prior to its transfer to the RSD shall transfer to the RSD an amount of money. This amount shall equal to the average per pupil amount appropriated or allocated for all students times

the number of students enrolled in the school transferred from its jurisdiction to the RSD from self-generated funds or any other appropriated state funds that exceeds the per pupil amount appropriated pursuant to R.S. 17:1990.C.(1).(a).

F. All amounts to be appropriated or allocated and transferred pursuant to this Section shall be estimated or calculated by the state Department of Education based on the most recent local revenue data and projected student counts available. Allocations to be transferred shall be adjusted during the year as necessary to reflect actual student counts and actual prior year local revenue collections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), and R.S. 17:1990.A.(2).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:311 (January 2011).

### **§1113. Purchasing and Contracts**

#### **A. Applicable Law and Policy**

1. The Recovery School District is established in R.S. 17:1990 as an intermediate education unit within the Department of Education and functions as a unit within a state agency, except as otherwise provided in R.S. 17:1990. State agencies are subject to various laws, regulations, and guidelines with respect to procuring goods and services needed by the agency. The Recovery School District, unlike other state agencies and unlike other units in the Department of Education, while still required to follow many procurement laws, has specific authority with respect to procurement that exempts it from receiving approval from other state agencies, where applicable, and exempts it from complying with state law applicable to other state agencies with respect to certain types of procurement.

2. The Recovery School District's authority relating to procurement:

a. requires the RSD to engage in the procurement of materials and supplies, telecommunications goods or services, data processing hardware, data processing software, software maintenance and support services, hardware services, major repairs, and public works in compliance with the processes established in law, regulation, and/or executive order, as applicable, but does not require the RSD to receive approval of such procurement from the Division of Administration or any other state agency that may exercise approval over such procurement. The RSD, although it must comply with Title 38 of the Louisiana Revised Statutes with respect to public works contracts, is not required to utilize any state selection board, including but not limited to, the Louisiana Architects Selection Board, the Louisiana Engineers Selection Board, or the Louisiana Landscape Architects Selection Board, when contracting for any public work; and

b. provides the RSD with the same authority and autonomy afforded to city, parish, or other local public school systems under state law regarding the procurement of services, including but not limited to professional, personal, consulting, operating, and social services, the procurement of immovable property, and the leasing of movable property. The authority and autonomy authorizes the RSD to procure such services without complying with the applicable provisions of Title 38 and Title 39 of the Louisiana Revised Statutes, which govern such procurement for all other state agencies.

3. RSD procurement shall be governed by all applicable law and BESE policy. Policy in reference to procurement is herein adopted by BESE in the exercise of its authority to approve the administration of the RSD.

#### **B. Scope**

1. The policy set forth herein shall act as the foundation upon which the State Superintendent shall develop procurement procedures and guidelines for the RSD in compliance with the parameters set forth herein. It shall not be construed as a detailed guide to carrying out procurement in the RSD.

2. All procedures and guidelines governing procurement in the RSD shall be in compliance with the policy set forth herein and shall be approved by the State Superintendent.

#### **C. Application**

1. This policy applies only to contracts entered into after the approval of the policy in this Section by BESE.

2. This policy shall apply to every expenditure of public funds, irrespective of their source, unless otherwise approved by BESE. This policy shall not apply to grants or contracts funded with federal funds, if procurement under such is governed by applicable federal law and regulation. Nothing in this policy shall prevent the RSD from complying with the terms and conditions of any grant, gift, or bequest.

3. This Section shall not apply to the procurement of services for the operation of a school under the jurisdiction of the RSD.

#### **D. Authority and Delegation**

1. In its approval of the administration of the RSD, BESE shall approve the parameters for procurement by the RSD, as set forth herein, and shall approve all RSD contracts, as defined herein.

2. Except as provided herein, the state superintendent is vested with procurement authority for the RSD and shall be responsible for the oversight and approval, as applicable, of all purchasing and contracting in the RSD.

3. The state superintendent may delegate procurement oversight and approval authority to the RSD superintendent, who may delegate such authority to the RSD procurement director or his or her superior, all as authorized herein.

4. When time is of the essence for a contract or contract amendment that requires board approval, such that the Recovery School District cannot wait for the next board meeting, though not an emergency as defined herein, the chairman of the Board Finance Committee and the board president may approve a contract or contract amendment upon the receipt of a written memorandum from the deputy superintendent of management & finance or his designee setting forth the request for approval, the reason for the request, the name of the contractor, the amount of the contract, the contract period, and a description of the services to be provided. The approval shall be reported to the board at its next meeting.

#### **E. State Superintendent Responsibilities**

1. The state superintendent shall ensure that the RSD has sufficient internal controls and capacity to manage procurement for the RSD.

2. The state superintendent shall require that procedures and/or guidelines, which govern all procurement

within the RSD, be developed. Such procedures and/or guidelines shall reflect the provisions of this policy. The state superintendent shall approve all procedures and/or guidelines governing RSD procurement.

a. Procurement procedures and/or guidelines shall contain, at a minimum, the following:

i. authority, roles, and responsibilities of all employees authorized to approve the procurement of goods and services;

ii. types of authorized and unauthorized contracts;

iii. source selection and contract formation;

iv. contract approval process;

v. contract administration;

vi. types of procurement and procedures for engaging in each;

vii. types of competitive processes to be used for each type of procurement;

viii. ethics in public procurement and contracting;

ix. emergency declaration procedures;

x. dispute resolution; and

xi. debarment.

3. The state superintendent shall implement a written approval process for the approval of all contracts that he/she is authorized to approve and all contracts to be submitted to BESE for its approval. The state superintendent shall ensure that the RSD superintendent has a written approval process for all contracts he/she may approve pursuant to authority delegated by the state superintendent. These written approval processes shall be delineated in the procedures and/or guidelines which govern all procurement within the RSD.

#### F. Definitions

1. See Section 2703.D. of this bulletin for definitions of relevant purchasing and financial terms. [Source: this is new, to collect all definitions in the bulletin in a single location at end of bulletin.]

#### G. Types of Procurement

1. The types of procurement that may be undertaken by the RSD and which are subject to the parameters set forth in this policy include, but are not limited to:

a. purchase of items available under state contracts;

b. materials and supplies;

c. telecommunications goods and services;

d. data processing hardware;

e. data processing software;

f. data processing software maintenance;

g. data processing support and hardware services;

h. major repairs;

i. public works contracts;

j. purchase of immovable property;

k. lease of immovable property;

l. professional services;

i. professional services identified in law; and

ii. other professional services,

m. personal services;

n. consulting services;

o. operating services;

p. social services; and

q. other service contracts.

2. All procurement not specifically listed herein shall be subject to the approval of the State Superintendent.

#### H. Contractual Arrangements

##### 1. Contract Form and Evidence of Obligation

a. All agreements to provide services to the RSD shall be evidenced by a written contract.

b. All contracts entered into by the RSD shall contain, at a minimum, all provisions contained in form contracts used by the Department of Education.

c. Absent a written contract for the performance of services, the RSD shall have no legal obligation to pay for services rendered and shall not make payments to satisfy any claim that is not based on a fully executed written contract.

##### 2. Prohibited Contracts

a. The RSD shall not enter into the following types of contracts:

i. contracts providing for the payment of cost plus a percentage of costs; or

ii. contingency fee contracts.

##### 3. Term of Contract and Multi-Year Contracts

a. The RSD shall not enter into any contract for a term that exceeds that which is prescribed in law for the respective types of procurement identified herein, regardless of the applicability of the law pursuant to R.S. 17:1990.

b. BESE shall approve all multi-year contracts entered into by the RSD, consistent with the thresholds provided herein. The RSD shall provide a justification for the need for a multi-year contract with the submission of each multi-year contract for BESE approval.

##### 4. Contract Amendments and Cumulating Multiple Contracts

a. The thresholds established for the use of a competitive process as set forth in this Section shall apply to contracts for which an amendment thereto causes the contract to exceed the applicable threshold and multiple contracts with the service provider or any company which has engaged the service provider, which, when cumulated, exceed the applicable threshold. This Subparagraph shall apply to contracts entered into within a fiscal year.

b. The thresholds established for BESE approval of contracts as set forth in this Section shall apply to contracts for which an amendment thereto causes the contract to exceed the applicable threshold and multiple contracts with the service provider or any company which has engaged the service provider, which, when cumulated, exceed the applicable threshold. This Subparagraph shall apply to contracts entered into within a fiscal year.

c. The state superintendent or his designee has the authority to approve amendments that result in no-cost extensions to current contracts. [This is new.]

##### 5. Commencement of Services under Contract

a. All services performed pursuant to a contract shall not commence prior to the approval of the contract, as set forth herein.

##### 6. Administration of Contracts

a. All contracts shall be administered and monitored by the RSD, including but not limited to, substantiating invoices, monitoring progress of work, and evaluating performance.

##### 7. Documentation of Contracts

a. Documentation related to all contracts shall be maintained pursuant to the RSD and/or Department of Education's Records Retention Schedule, as applicable.

## 8. Contract Reporting

a. The state superintendent shall provide a report to BESE of all contracts entered into by the RSD, other than major repair or public works contracts, consistent with contract reporting performed by the Department of Education.

b. The state superintendent shall provide a report to BESE of all major repair or public works contracts as determined by BESE.

### I. Procurement Executed Pursuant to Applicable Law

#### 1. Purchase of Items Available Under State Contracts

a. The RSD shall purchase all products or services available under state contracts entered into by the Division of Administration, unless a product or service being purchased can be obtained at a lower cost or the state superintendent determines that it is in the best interest of the RSD to independently procure the product or service.

b. The state superintendent shall require that a record be created of all procurement of products or services available under state contract, but which the RSD does not procure through a state contract. The record shall include the justification for the purchase of such products or services other than that which is available through a state contract.

c. The exceptions set forth in Subparagraph 1.a. above shall not apply if purchasing from a state contract is mandatory, as prescribed by the Division of Administration. In such case, the RSD shall comply with all applicable exceptions provided in law or regulation.

#### 2. Materials and Supplies

a. The RSD shall comply with all applicable law when procuring materials and supplies.

b. The state superintendent shall have the authority to delegate his authority to procure materials and supplies to the RSD superintendent, who shall have that authority to delegate the same to the RSD procurement director.

c. The RSD superintendent may delegate his authority to procure materials and supplies to school level personnel, subject to procedures and purchasing thresholds approved by the state superintendent.

#### 3. Telecommunications Goods and Services, Data Processing Hardware, Data Processing Support, and Hardware Services

a. The RSD shall comply with all applicable law when procuring telecommunications goods and services, data processing hardware, data processing support, and hardware services.

b. The state superintendent shall have the authority to delegate his authority to procure telecommunications goods and services, data processing hardware, data processing support, and hardware services to the RSD superintendent, who shall have that authority to delegate the same to the RSD procurement director.

c. All service contracts resulting from procurement of telecommunications goods and services, data processing hardware, data processing support, and hardware services shall be subject to BESE approval as defined in Subparagraph K.2.b. of this Section.

#### 4. Data Processing Software

a. The RSD shall comply with all applicable law when procuring data processing software.

b. The RSD procurement procedures and guidelines shall ensure the participation of a committee of no less than

three individuals, with expertise appropriate to the software being selected, in the selection of data processing software.

c. The state superintendent shall have the authority to delegate his authority to procure data processing software to the RSD superintendent, who shall have that authority to delegate the same to the RSD procurement director.

### 5. Small Purchases

a. The RSD may engage in small purchases pursuant to R.S. 39:1596 and any Executive Order issued pursuant thereto.

b. The state superintendent shall have the authority to delegate his authority to engage in small purchases to the RSD superintendent, who shall have that authority to delegate the same to the RSD procurement director.

### 6. Used Equipment

a. The RSD may purchase used equipment, pursuant to Title 39 of the Louisiana Revised Statutes, when the purchase of used equipment is cost effective to the RSD.

b. The state superintendent shall have the authority to delegate his authority to purchase used equipment to the RSD superintendent, who shall have that authority to delegate the same to the RSD procurement director.

### 7. Major Repairs

a. The RSD shall comply with all applicable law when procuring major repairs.

b. BESE shall approve all major repair contracts exceeding \$250,000 and all amendments to such contracts.

c. The state superintendent shall have the authority to approve all major repair contracts exceeding \$250,000 if such contracts are entered into pursuant to an emergency condition as defined in applicable law and policy.

d. The state superintendent shall have the authority to approve all major repair contracts not exceeding \$250,000.

e. The state superintendent shall have the authority to delegate his authority to approve major repair contracts not exceeding \$50,000 to the RSD superintendent.

### 8. Public Works Contracts

a. The RSD shall comply with all applicable law when entering into public works contracts.

b. BESE shall approve all public works contracts exceeding \$250,000 and all amendments to such contracts.

c. The state superintendent shall have the authority to approve all public works contracts not exceeding \$250,000.

### J. Procurement Executed Pursuant to BESE Policy

#### 1. Professional Services Contracts Involving Professionals Identified in Louisiana Law

a. All professional services identified in Title 39 of the Louisiana Revised Statutes, which include lawyers, doctors, dentists, psychologists, certified advanced practice nurses, veterinarians, architects, engineers, land surveyors, landscape architects, accountants, actuaries, and claims adjusters shall be procured in compliance with applicable law.

b. The state superintendent shall develop and implement a process for the procurement of the professional services of architects, landscape architects, and engineers, which ensures that such professionals have the ability to participate in RSD projects and that professionals qualifying to participate have demonstrated competence and qualifications for the type of services required.

c. The process for the procurement of the professional services of architects, landscape architects, and engineers shall be approved by BESE.

d. BESE shall approve all professional service contracts exceeding \$50,000 and all amendments to such contracts.

e. The state superintendent shall have the authority to approve all contracts not exceeding \$50,000 and shall have the authority to delegate such approval authority to the RSD superintendent.

### 2. Other Professional Services, Personal Services, and Consulting Services

a. All professional services not specifically identified in Title 39 of the Louisiana Revised Statutes, as set forth in Paragraph 1 above, and all other service contracts, except for personal service contracts, which shall not require a competitive process regardless of the amount of the personal service contract, shall be procured through the use of a competitive process for all contracts that will exceed \$50,000, subject to the exceptions provided herein.

b. BESE shall approve all service contracts exceeding \$50,000 and all amendments to such contracts.

c. The state superintendent shall have the authority to approve all contracts not exceeding \$50,000 and shall have the authority to delegate such approval authority to the RSD superintendent.

### 3. Social Service Contracts

a. All social service contracts shall be procured through the use of a competitive process for all contracts that will exceed \$150,000, subject to the exceptions provided herein.

b. BESE shall approve all social service contracts exceeding \$50,000 and all amendments to such contracts.

c. The state superintendent shall have the authority to approve all contracts not exceeding \$50,000 and shall have the authority to delegate such approval authority to the RSD superintendent.

### 4. Purchase or Lease of Immovable Property

a. The state superintendent shall develop and implement a process for the purchase or lease of immovable property.

b. BESE shall approve the purchase or lease of immovable property by the RSD.

### K. Exceptions to Required Competitive Process

1. Procurement that is governed by state law and regulation is set forth in Subsection I. of this Section. All requirements that must be met when engaging in such procurement are governed by applicable law and regulation. In addition, all exceptions to such requirements are governed by applicable law and regulation. The RSD must comply with all law and regulation, unless law or regulation authorizes an exception. The exceptions set forth below in Subparagraph K.2. for procurement which is governed by policy shall not apply to procurement governed by state law and regulation.

2. Procurement that is governed by BESE policy is set forth in Paragraph J. of this Section. The provisions of Paragraph J. require the use a competitive process for certain

types of procurement that are governed by policy. A competitive process shall not be required in the following circumstances:

### a. Declaration of an Emergency by State Superintendent

i. In all procurement wherein a competitive process is required by this policy, the RSD may engage in emergency procurement following the declaration of an emergency by the state superintendent or his designee. The state superintendent is authorized to delegate his authority to declare emergencies and/or approve emergency contracts to the RSD superintendent, the RSD chief operating officer, or the RSD chief procurement officer. The state superintendent or his designee may declare an emergency if an emergency condition, meeting the following criteria, exists.

(a). An emergency condition is a situation which creates a threat to public health, welfare, safety, or public property such as may arise by reason of floods, epidemics, riots, equipment failures, or such other reason as proclaimed by the state superintendent. The existence of such condition creates an immediate and serious need for supplies, services, or major repairs that cannot be met through normal procurement methods and the lack of which would seriously threaten:

- (i). the functioning of Louisiana government;
- (ii). the preservation or protection of property; or
- (iii). the health or safety of any person.

ii. The state superintendent shall require that a record be created of all emergency declarations by making a written determination stating the basis for an emergency procurement and for the selection of a particular contractor. In addition to the written determination describing the basis for the emergency procurement, the record shall also contain:

- (a). each contractor's name;
- (b). the amount and type of each contract; and
- (c). a listing of services procured under each contract.

iii. Emergency procurement shall be limited to only those services necessary to meet the emergency.

iv. The source selection method used shall be selected with the goal of assuring that the required services are procured in time to meet the emergency. Given this constraint, such competition as is practicable should be obtained.

### b. Sole Source Procurement

i. The RSD may engage in sole source procurement if the product or service it is seeking is available from a single supplier. The vendor must be the sole provider of any services requested.

ii. A requirement for a particular service does not justify a sole source procurement if there is more than one potential bidder or offeror for the service.

iii. The state superintendent shall require that a record be created of all sole source procurement by making a written determination stating the basis for the sole source

procurement and for the selection of a particular contractor. In addition to the written determination describing the basis for the sole source procurement, the record shall contain:

- (a). the contractor's name;
- (b). the amount and type of contract; and
- (c). a listing of services procured under the contract.

iv. All sole source contracts submitted to BESE for approval as required in this Section shall be accompanied by a description of the basis for exercising the sole source exception. Each amendment to such contracts submitted for BESE approval shall also contain an assurance that the services to be provided through the contract amendment continue to meet the sole source exception provided herein.

v. For all contracts with a sole source provider which have been entered into pursuant to the exception set forth in this Subparagraph, the contractor shall be allowed to subcontract with a provider of services to be compensated through its contract with the RSD, even if the subcontractor does not meet the criteria for being a sole source provider, as long as the subcontractor's work is a part of the overall contract objective and the contract is predominantly a contract for the services of the sole source provider.

c. Service Contracts with Education Program Specialists

i. The RSD may enter into a personal service, consulting service, or other professional service contract, as set forth in Paragraph J.2. of this Section, without using a competitive process upon a specific determination of the following:

(a). the service proposed to be provided by the education program specialist is directly related to efforts to improve student academic achievement;

(b). the service proposed to be provided by the education program specialist is directly related to the development of an academic organizational structure; or

(c). the service proposed to be provided by the education program specialist is directly related to efforts to provide services to students with disabilities.

ii. The state superintendent shall require that a record be created for each education program specialist contract entered into without the use of a competitive process by making a written determination stating the basis for the procurement and for the selection of a particular contractor. In addition to the written determination describing the basis for the procurement and for the selection of a particular education program specialist, the record shall contain:

- (a). the contractor's name;
- (b). the amount and type of each contract;
- (c). a listing of the services to be provided; and
- (d). an explanation of the how the contractor meets a category in Clause K.2.c.i. of this Section.

iii. All education program specialist contracts submitted to BESE for approval as required in this Section shall be accompanied by a description of the basis for exercising the education program specialist exception. The basis shall include evidence that the contractor qualifies as an education program specialist and an explanation of how the contractor meets a category in Clause K.2.c.i. of this Section. Each amendment to such contracts submitted for

BESE approval shall also contain an assurance that the services to be provided through the contract amendment continue to meet the education service provider exception provided herein.

iv. For all contracts with an education program specialist which have been entered into pursuant to the exception set forth in this Subparagraph, the contractor shall be allowed to subcontract with a provider of services to be compensated through its contract with the RSD, even if the subcontractor does not meet the criteria for being an education program specialist, as long as the subcontractor's work is a part of the overall contract objective and the contract is predominantly a contract for the services of an education program specialist.

L. Cooperative Purchasing

1. The RSD shall have the authority to join with other school districts, the State of Louisiana, or other units of government in cooperative purchasing plans when such purchasing is in the best interest of the RSD. Competitive sealed bids or sealed proposals received by any other governmental agency or school district shall be the equivalent of bids or proposals received by the RSD and may be the basis for purchase of goods and services by the RSD.

M. Federal General Services Administration (GSA) Contracts

1. The RSD may procure materials, supplies, and equipment from Federal General Services Administration supply schedules in compliance with the Federal Acquisition Streamlining Act and regulations adopted pursuant to that law. Such purchases of materials, supplies, or equipment shall not be purchased at a price higher than the price for the same item listed on any available state purchasing contract. No use shall be made of the federal GSA supply schedules with the participation of a Louisiana licensed dealer or distributor.

N. Waiver of Requirements

1. BESE may waive, or deviate from, any provision of this Section upon the request of the State Superintendent.

2. The State Superintendent, in requesting such a deviation or waiver, shall identify the provision to be waived or the provision from which the State Superintendent seeks to deviate, and shall provide a justification for the request.

3. Any request for a deviation from, or for a waiver of, any provision of this Section shall be approved by BESE prior to the execution of any contract or contract amendment pursuant to such waiver or deviation and prior to commencement of work by any contractor pursuant to any such contract or contract amendment.

4. The agenda of the Finance/Audit Review Committee shall have a standing item wherein the State Superintendent may make a request defined in this Paragraph.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 17:10.5.A.(1), R.S. 17:10.7.A.(1), R.S. 17:1990.A.(2), and R.S. 39:1596.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:312 (January 2011).

Jeanette Vosburg  
Executive Director

1101#066

## RULE

### Office of the Governor Board of Examiners of Certified Shorthand Court Reporters

General Requirements for Certified Digital Reporters  
(LAC 46:XXI.101, 105, 317, 501,  
511, 609, 901, 1103, and 1301)

In accordance with the Administrative Procedures Act, R. S. 49:950 et seq., the Louisiana Board of Examiners of Certified Shorthand Reporters has adopted and amended rules as required under ACT 700 of the 2010 Regular Legislative Session. The following rules have been adopted or amended: Certification, Grandfathering Certification, Examinations, Certificates, Methods of Reporting, Continuing Education, Fees, Court Reporting Procedures, and Code of Ethics.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XXI. Certified Shorthand Reporters

#### Chapter 1. Certification

##### §101. Application for Certification

A. ...

B. An application for a certified digital reporter certificate will be processed according to the following procedure. The board staff will review each application for completeness and will notify the applicant in writing if the application is incomplete or inadequate. The board may request additional information from an applicant at any time during the application process. Each application must be accompanied by the fee to be paid upon issuance and renewal of a certificate as stated in Chapter 9 of these rules. A certified digital reporter certificate authorizes the certificate holder to practice court reporting only as an official or deputy official court reporter performing duties for a court of record. The holder of a CDR certificate is prohibited from engaging in freelance or general reporting. This certificate is only portable to another court if the applicant holds the Electronic Reporters and Transcribers certificate from the American Association of Electronic Reporters and Transcribers (AAERT) or any other national or state recognized association or organization which is approved by the board and authorized or licensed to provide education and certification for professionals engaged in digital reporting and transcribing a verbatim record of oral court proceedings, and which is approved by the judge or court employing the services of the court reporter, or any official or deputy official reporter who has satisfied equivalent testing and certification requirements established by the board. If the certificate is allowed to lapse, the seal(s) shall be returned to the board. Each holder of a CDR certificate is subject to the regulatory authority of the board and must satisfy the requirements applicable to court reporters, such as compliance with continuing education requirements, and adherence to the standards of professional conduct.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2554 and 2556.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Examiners of Certified Shorthand Reporters,

LR 9:678 (October 1983), amended by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 14:530 (August 1988), LR16:393 (May 1990), LR 19:1537 (December 1993), LR 37:317 (January 2011).

##### §105. Grandfathering Certification

A. On or before December 31, 2010, the board will accept applications for the Certificate of Certified Digital Reporter from any person age 18 years or older who submits due proof that the person is employed as an official or deputy official court reporter by a Louisiana court of record and that the person has utilized electronic, audio, or digital recording equipment as a method of official court reporting. The board will accept as due proof of employment the board approved CDR application and judge or court affidavit. The affidavit shall be executed by the judicial administrator or judge of that court of record attesting, that the applicant is employed by that court as of the date of execution. The board will receive and consider applications for a CDR certificate based on grandfathering at any time on or before December 31, 2010. The board will not consider or approve applications for issuance of a CDR certificate by official or deputy official court reporters employed by the following courts: Fifteenth, Sixteenth, Seventeenth, Nineteenth, Thirty-Second, Thirty-Fourth, and Fortieth Judicial District Courts, the Orleans Parish Civil District Court, the Orleans Parish Criminal District Court, the Jefferson Parish First and Second Parish Courts, the New Orleans First and Second City Courts, the New Orleans Municipal and Traffic Courts, and on and after the effective date of its creation, the Forty-First Judicial District Court. Following submission of satisfactory proof in accordance with the foregoing requirements, the board will approve issuance of a CDR certificate.

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:2554 and 2556.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Examiners of Certified Shorthand Reporters, LR 37:317 (January 2011).

#### Chapter 3. Examinations

##### §317. National Examinations

A. ...

B. The board will accept as an examination the Electronic Reporter and Transcriber certificate from the American Association of Electronic Reporters and Transcribers (AAERT). A certificate holder under this Chapter is prohibited from engaging in freelance or general reporting.

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:2554 and 2556.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Examiners of Certified Shorthand Reporters, LR 9:678 (October 1983), amended by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 14:531 (August 1988), LR 21:931 (September 1995), LR 27:184 (February 2001), LR 37:317 (January 2011).

#### Chapter 5. Certificates

##### §501. Expiration of Certificate

A. ...

B. The certified digital reporter certificate is immediately extinguished by operation of law upon termination of the certificate holder's employment by that court if he or she was grandfathered in as a CDR. A CDR shall immediately notify the board of any change in employment status and

shall surrender the certificate upon termination of employment by that court of record. If a grandfathered CDR certificate lapses, then the certificate holder must begin anew by obtaining the Electronic Reporter and Transcriber certificate from the American Association of Electronic Reporters and Transcribers (AAERT).

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:2554.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Examiners of Certified Shorthand Reporters, LR 9:678 (October 1983), amended by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 14:531 (August 1988), LR 19:1538 (December 1993), LR 37:317 (January 2011).

#### **§511. Methods of Reporting**

A. Each reporter shall be certified in one of the following four five methods of reporting.

1. - 4. ...

5. Digital. A certified digital reporter is anyone who converts an electronic, audio, or digital recording into a verbatim transcript of any oral court proceeding, is prohibited from freelance or general reporting, is restricted to duties as an official or deputy official court reporter, and has been certified to engage in the practice of digital reporting as a certified electronic reporter and transcriber by the American Association of Electronic Reporters and Transcribers, or anyone who has submitted due proof on or before December 31, 2010 that the person is employed as an official or deputy official court reporter by a Louisiana court of record on or before December 31, 2010 and that the person has performed the duties of an official or deputy official court reporter utilizing electronic, audio, or digital recording equipment as a method of official court reporting.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2554, 2555, 2556 and R.S. 37:2557.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 20:997 (September 1994), LR 37:318 (January 2011).

### **Chapter 6. Continuing Education**

#### **§609. Continuing Education Guidelines**

A. ...

1. The board may approve seminars and workshops sponsored by the National Court Reporters Association (NCRA) or, the National Verbatim Reporters Association (NVRA) or the American Association of Electronic Reporters and Transcribers (AAERT) at national, regional, state, or local meetings, by public institutions of higher learning, and by judicial organizations, including the following subjects:

A.1.a. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2554.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 17:33 (January 1991), amended LR 19:1539 (December 1993), amended by the Office of the Governor, Board of Examiners of Certified Shorthand Reporters, LR 33:2420 (November 2007), LR 37:318 (January 2011).

### **Chapter 9. Fees**

#### **§901. Fees**

A. - A.1. ...

2. The fee to be paid upon the issuance and renewal of the a certificate of registration is \$125 plus seal fee(s).

3. The fee to be paid for a seal is \$20. A minimum requirement of one seal must be purchased upon the issuance or renewal of a certificate. The maximum number of seals that may be purchased is three per certificate holder.

4. - 8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2554 and 2558.

HISTORICAL NOTE: Promulgated by the Department of Commerce, Board of Examiners of Certified Shorthand Reporters, LR 9:680 (October 1983), amended LR 10:279 (April 1984), amended by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 14:531 (August 1988), LR 17:34 (January 1991), LR 17:578 (June 1991), LR 19:1541 (December 1993), amended by the Office of the Governor, Board of Examiners of Shorthand Reporters, LR 34:434 (March 2008), LR 36:1781 (August 2010), LR 37:318 (January 2011).

### **Chapter 11. Court Reporting Procedures**

#### **§1103. Certification of Transcript**

A. - B. ...

C. Each certified digital reporter (CDR) shall attest to the accuracy of every transcript prepared by that reporter by dating, signing, and sealing a certification page containing substantially the following language.

This certificate is valid only for a transcript accompanied by my original signature and original seal on this page.

I, [reporter's name]. Certified Digital Reporter in and for the State of Louisiana, employed as an official or deputy official court reporter by the [court name] for the State of Louisiana, as the officer before whom this testimony was taken, do hereby certify that this testimony was reported by me in the digital reporting method, was prepared and transcribed by me or under my direction and supervision, and is a true and correct transcript to the best of my ability and understanding and that I am not related to counsel or to the parties herein nor am I otherwise interested in the outcome of this matter.

D. No certified digital reporter shall execute the foregoing certification without having first reviewed and approved the accuracy of the transcript to which such certification is attached.

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:2554 and R. S. 37:2557.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 21:21 (January 1995), LR 37:318 (January 2011).

### **Chapter 13. Code of Ethics**

#### **§1301. Guidelines for Professional Practice**

A. The mandatory Code of Ethics defines the ethical relationship the public, the bench, and the bar have a right to expect from a certificate holder. It sets out the required conduct of the certificate holder when dealing with the user of reporting services, and acquaints the user, as well as the certificate holder, with guidelines established for professional behavior.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R. S. 37:2553(A.), 37:2554 and 37:2557(A).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 25:1215 (July 1999), amended by the

Judge Robert M. Murphy  
Chair

1101#064

## RULE

### Office of the Governor Commission on Law Enforcement and Administration of Criminal Justice

#### Peace Officer Training (LAC 22:III.Chapter 47)

In accordance with the provision of R.S. 40:2401, et seq., the Peace Officer Standards and Training Act, and R.S. 40:905 et seq., which is the Administrative Procedure Act, the Peace Officer Standards and Training Council hereby promulgates rules and regulations relative to the training of peace officers.

#### Title 22

### CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

#### Part III. Commission on Law Enforcement and Administration of Criminal Justice

##### Subpart 4. Peace Officers

#### Chapter 47. Standards and Training

##### §4705. Registration

A. Registration may be granted in lieu of certification to those peace officers who:

1. were hired prior to January 1, 1986;
2. did not attend POST-certified basic training; and
3. are currently performing the duties of a peace officer.

B. *Registration* simply means that the officer is registered with POST and he/she is not required to comply with the mandates for basic POST certification.

C. Officers hired prior to January 1, 1986, may be eligible to receive POST registration by completing the following requirements.

1. Submit a letter to the POST Council from the agency head requesting the officer be registered with the state.
2. Supporting documentation shall accompany the letter regarding initial employment date along with a chronological narrative of the officer's law enforcement service on a form prescribed by POST.

D. Registered officers who are "grandfathered in" are exempt from the basic training course requirement but must comply with all other POST mandates to maintain grandfathership.

E. Registration/grandfatherhood shall become invalid if officer experiences a five year or more break in law enforcement service and has less than five years full time experience.

F. Officers, who were hired prior to January 1, 1986, and who experience a five year or more break in law enforcement, and had at least five years of full-time service, can reinstate their grandfatherhood by successfully completing:

1. the firearms section of the Louisiana Law Enforcement Basic Training Manual;
2. the legal aspects of the Louisiana Law Enforcement Basic Training Manual; and
3. the necessary requirements for POST registration in accordance with the provisions of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:1204 and R.S. 15:1207.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, LR 13:434 (August 1987), amended LR 25:663 (April 1999), LR 31:3159 (December 2005), LR 37:319 (January 2011).

##### §4709. Interruption of Full-Time Service

A. ...

1. at least a minimum of five years experience, then the officer must meet the requirement of §4705.F; or

A.2. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:1204 and R.S. 15:1207.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, LR 13:434 (August 1987), amended LR 25:664 (April 1999), LR 31:3159 (December 2005), LR 34:1927 (September 2008), LR 37:319 (January 2011).

Mr. Joey Watson  
Executive Director

1101#049

## RULE

### Office of the Governor Office of Elderly Affairs

#### State Plan on Aging (LAC 4:VII.1301-1305)

In accordance with R.S. 49:950 et seq., the Administrative Procedures Act, the Governor's Office of Elderly Affairs (GOEA) has amended LAC 4:VII.1301-1305.

The purpose of this amended Rule is to acknowledge that the Office of Elderly Affairs will develop a state plan that will be submitted to the U.S. Department of Health and Human Services, Administration on Aging to receive grants from its allotment under Title III of the Older Americans Act of 1965 as amended (the Act). Title III authorizes formula grants to state agencies on aging to assist states and local communities to develop comprehensive and coordinated systems for the delivery of services to older persons.

#### Title 4

### ADMINISTRATION

#### Part VII. Governor's Office

#### Chapter 13. State Plan on Aging

##### §1301. State Plan on Aging

A. To receive funding from the Older Americans Act the State Agency on Aging must have an approved State Plan on Aging. This plan must be on file with the Administration on Aging and be available for public review. At the minimum, the plan must include:

1. identification by the state of the sole state agency that has been designated to develop and administer the plan;
2. statewide program objectives to implement the requirements under Title III of the Act and any objectives

established by the commissioner through the rulemaking process;

3. a resource allocation plan indicating the proposed use of all Title III funds administered by the state agency and the distribution of Title III funds to each planning and service area;

4. identification of the geographic boundaries of each planning and service area and of area agencies on aging;

5. prior federal fiscal year information related to low income minority and rural older individuals;

6. all assurances and provisions as outlined in the Older Americans Act and regulations, as well as the following assurances:

a. preference is given to older persons in greatest social or economic need in the provision of services under the plan;

b. procedures exist to ensure that all services under this part are provided without use of any means tests;

c. all services provided under Title III meet any existing state and local licensing, health and safety requirements for the provisions of those services;

d. older persons are provided opportunities to voluntarily contribute to the cost of services;

e. other such assurances as are needed for compliance with the Act, regulations, other applicable federal law, state statutes, and/or state policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:342 (April 1985), amended LR 12:366 (June 1986), LR 12:511 (August 1986), LR 13:569 (October 1987), LR 17:1207 (December 1991), LR 19:1317 (October 1993), LR 23:1146 (September 1997), LR 26:1610 (August 2000), LR 30:1695 (August 2004), LR 35:662 (April 2009), LR 37:320 (January 2011).

### **§1303. Development of the State Plan**

A. The state agency will develop a state plan according to the following:

1. elect to utilize a one-, two-, three-, or four-year format for the state plan;

2. develop a data profile on the older Louisianans from available census data;

3. conduct statewide needs assessment activities including, but not limited to, public hearings;

4. assurances for state and area agencies on aging as set forth by the Older Americans Act;

5. goals and objectives;

6. publicize public hearing(s) giving dates, times, locations to public officials and other interested parties for their participation;

7. conduct public hearings and incorporate written and verbal comments into the revised plan, as appropriate;

8. submit final revised plan for approval by the governor;

9. submit approved plan from the governor to the Administration on Aging Regional Office for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:342 (April 1985), amended LR 12:366 (June 1986), LR 12:511 (August 1986), LR 13:569 (October 1987), LR 15:263 (April 1989), LR 17:1207

(December 1991), LR 19:1317 (October 1993), LR 23:1146 (September 1997), LR 26:1611 (August 2000), LR 30:1696 (August 2004), LR 35:662 (April 2009), LR 37:320 (January 2011).

### **§1305. Intrastate Funding Formula**

A. Intrastate Funding Formula

1. The following is a descriptive summary of the current Intrastate Funding Formula's assumptions and goals, and the application of the definitions of greatest economic or social need and a demonstration of the allocation of funds, pursuant to the formula, to each PSA.

2. Descriptive Statement

a. The current intrastate funding formula for the distribution of Older Americans Act Title III funds in Louisiana provides for a base allocation by parish. The following factors are considered in the distribution of funds remaining after base allocations are made: population aged 60 and over; population aged 60 and over below the Bureau of the Census poverty threshold; population aged 75 and over; and land area in square miles. Each of these factors is derived by dividing the planning and service area total by the state total.

b. Population aged 60 and over, and land area in square miles is assigned weights of one each. Population aged 60 and over below the Bureau of the Census poverty threshold is assigned a weight of nine-tenths. Population aged 75 and over is assigned a weight of one-tenth. The sum of these four factors is three.

c. Those elderly in greatest economic need are defined as persons aged 60 and older whose incomes are at or below the poverty threshold established by the Bureau of the Census. Those elderly in greatest social need are defined as persons aged 60 and over who have needs based on noneconomic factors such as social isolation caused by living in remote areas, or who are especially vulnerable due to the heightened possibility of frailty among elderly aged 75 and older. Other social needs are those, which restrict an elderly individual's ability to perform normal daily tasks, or which restrict his or her ability to live independently; they can be caused by racial or ethnic status, or language barriers. The intrastate funding formula accounts for these individuals by not allocating funds solely on the basis of population. The land area in square miles factor is included to compensate area agencies serving predominantly rural areas for the special problems encountered by sparse populations who may be spread over large geographical areas. The four funding factors combine to meet the special needs of socially and economically needy elderly, urban elderly and rural elderly.

d. The base funding allocation of \$12,000 per parish is established on the assumption that this amount represents a minimum allocation for the administration of Older Americans Act programs. There is an increasing need to provide a continuum of care for the very old (aged 75 and older) as this segment of the population gets larger each year. Funding limitations dictate that this group is given special emphasis.

3. Numerical Statement of the Intrastate Funding Formula

a. Base Allocation per PSA: \$12,000 per parish.

b. Formula Allocation per PSA:

Factors	Weight
PSA 60+ Population State 60 + Population	1.0
PSA 60+ Below Poverty Threshold State 60+ Population Below Poverty Threshold	0.9
PSA Land Mass in Square Miles State Land Mass in Square Miles	1.0
PSA 75+ Population State 75+ Population	0.1
Sum	3.0

4. 
$$PSA\ FORMULA = (i) \times 1 + (ii) \times 0.9 + (iii) \times 1 + (iv) \times 0.1$$

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 11:342 (April 1985), amended LR 12:366 (June 1986), LR 12:511 (August 1986), LR 13:569 (October 1987), LR 17:1207 (December 1991), LR 19:1317 (October 1993), LR 23:1146 (September 1997), LR 26:1611 (August 2000), LR 30:1696 (August 2004), LR 35:662 (April 2009), LR 37:320 (January 2011).

**§1307. - §1323. Reserved.**

Paul Colomb  
Appointing Authority

1101#023

**RULE**

**Office of the Governor  
Public Defender Board**

**Trial Court Performance Standards For Attorneys  
Representing Parents in Child in Need of Care and  
Termination of Parental Rights Cases  
(LAC 22:XV.Chapter 11)**

The Public Defender Board, a state agency within the Office of the Governor, has adopted LAC 22:XV.Chapter 11, as authorized by R.S. 15:148. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 307 of the 2007 Regular Session of the Louisiana Legislature directed the Public Defender Board to adopt rules creating mandatory: 1) statewide public defender standards and guidelines that require public defender services to be provided in a manner that is uniformly fair and consistent throughout the state; and 2) qualification standards for public defenders that ensure that the public defender services are provided by competent counsel. Said standards are to ensure that public defenders are qualified to handle specific case types which shall take into consideration the level of education and experience that is necessary to competently handle certain cases and case types, including representation of parents in child in need of care cases. In compliance with the directives of Act 307, the Public Defender Board adopts these standards for trial court performance for representation of parents in child in need of care cases.

**Title 22  
CORRECTIONS, CRIMINAL JUSTICE AND LAW  
ENFORCEMENT  
Part XV. Public Defender Board  
Chapter 11. Trial Court Performance Standards for  
Attorneys Representing Parents in Child  
in Need of Care Cases**

**§1101. Purpose**

A. The standards for parent representation in child in need of care cases are intended to serve several purposes. First and foremost, the standards are intended to encourage district public defenders, assistant public defenders and appointed counsel to perform to a high standard of representation and to promote professionalism in the representation of parents in child in need of care and termination of parental rights cases.

B. The standards are also intended to alert defense counsel to courses of action which may be necessary, advisable, or appropriate, and thereby to assist attorneys in deciding upon the particular actions to be taken in each case to ensure that the client receives the best representation possible. The standards are further intended to provide a measure by which the performance of district public defenders, assistant public defenders and appointed counsel may be evaluated, including guidelines for proper documentation of files to demonstrate adherence to the Standards, and to assist in training and supervising attorneys.

C. The language of these standards is general, implying flexibility of action which is appropriate to the situation. In those instances where a particular action is absolutely essential to providing quality representation, the standards use the word "shall." In those instances where a particular action is usually necessary to providing quality representation, the standards use the word "should." Even where the standards use the word "shall," in certain situations, the lawyer's best informed professional judgment and discretion may indicate otherwise.

D. These standards are not criteria for the judicial evaluation of alleged misconduct of defense counsel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:321 (January 2011).

**§1103. Obligations of Defense Counsel**

A. The primary and most fundamental obligation of an attorney representing a parent in a child in need of care or a termination of parental rights case is to provide zealous and effective representation for his or her client at all stages of the process. The defense attorney's duty and responsibility is to promote and protect the expressed interests of the client. If personal matters make it impossible for the defense counsel to fulfill the duty of zealous representation, he or she has a duty to refrain from representing the client. Attorneys also have an obligation to uphold the ethical standards of the Louisiana Rules of Professional Conduct, to act in accordance with the Louisiana Rules of Court, and to properly document case files to reflect adherence to the standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:321 (January 2011).

#### **§1105. General Duties of Defense Counsel**

A. Before agreeing to act as counsel or accepting appointment by a court, counsel has an obligation to make sure that counsel has available sufficient time, resources, knowledge and experience to offer effective representation to a parent in a child in need of care or termination of parental rights proceeding. If it later appears that counsel is unable to offer effective representation in the case, counsel should move to withdraw.

B. Counsel shall be alert to all potential and actual conflicts of interest that would impair counsel's ability to represent a parent. Counsel shall not represent both parents if their interests differ. The attorney should generally avoid representing both parents when there is even potential for conflict of interest. In situations involving allegations of domestic violence, the attorney shall not represent both parents. When appropriate, counsel may be obliged to seek an advisory opinion from the Office of Disciplinary Counsel on any potential conflicts.

C. If a conflict is discovered during the course of representation, counsel has a duty to notify the parent and the court in accordance with the Louisiana Rules of Court and in accordance with the Louisiana Rules of Professional Conduct.

D. Counsel has the obligation to take all reasonable steps to keep the parent informed of the progress of the case.

E. Counsel has the obligation to ensure that the case file is properly documented to demonstrate adherence to the standards, such as, where relevant, documentation of intake and contact information, client and witness interviews, critical deadlines, motions, and any other relevant information regarding the case. The case file should also contain, where relevant, copies of all pleadings, orders, releases (school, medical, mental health, or other types), discovery, and correspondence associated with the case.

F. When counsel's caseload is so large that counsel is unable to satisfactorily meet these performance standards, counsel shall inform the district defender for counsel's judicial district and, if applicable, the regional director. If the district defender determines that the caseloads for his entire office are so large that counsel is unable to satisfactorily meet these performance standards, the district defender shall inform the court or courts before whom cases are pending and the state public defender.

G. Lawyers initially appointed should continue their representation through all stages of the proceedings. Unless otherwise ordered by the court, the attorney of record should continue to represent the client from the point of the initial court proceedings through disposition, post-disposition review hearings, and any other related proceedings until the case is closed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:322 (January 2011).

#### **§1107. Training and Experience of Defense Counsel Representing a Parent in a Child in Need of Care or Termination of Parental Rights Proceeding**

A. In order to provide quality legal representation, counsel shall be familiar with the substantive juvenile law and the procedure utilized in child in need of care proceedings, including but not limited to Title VI of the Louisiana Children's Code (La. Ch.C. Articles 601 et seq.), Title X of the Louisiana Children's Code (La. Ch.C. Articles 1001 et seq.) and their applications in the State of Louisiana. Counsel has a continuing obligation to stay abreast of changes and developments in the law.

B. Prior to agreeing to undertake representation of a parent in a child in need of care or termination of parental rights proceeding, counsel shall have sufficient experience or training to provide effective representation. It is essential for the parent's attorney to read and understand all state laws, policies and procedures regarding child abuse and neglect. In addition, the parent's attorney should be familiar with the following laws to recognize when they are relevant to a case and should be prepared to research them when they are applicable:

1. Titles IV-B and IV-E of the Social Security Act, including the Adoption and Safe Families Act (ASFA), 42 U.S.C. §§ 620-679 and the ASFA Regulations, 45 C.F.R. Parts 1355, 1356, 1357;

2. Fostering Connections to Success and Increasing Adoptions Act of 2008, P.L. 110-351;

3. Child Abuse Prevention Treatment Act (CAPTA), P.L.108-36;

4. Indian Child Welfare Act (ICWA) 25 U.S.C. §§ 1901-1963, the ICWA Regulations, 25 C.F.R. Part 23, and the Guidelines for State Courts: Indian Child Custody Proceedings, 44 Fed. Reg. 67, 584 (Nov. 26, 1979);

5. State Indian Child Welfare Act laws;

6. Multi-Ethnic Placement Act (MEPA), as amended by the Inter-Ethnic Adoption Provisions of 1996 (MEPA-IEP) 42 U.S.C. § 622 (b)(9) (1998), 42 U.S.C. § 671(a)(18) (1998), 42 U.S.C. § 1996b (1998);

7. Interstate Compact on Placement of Children (ICPC);

8. Foster Care Independence Act of 1999 (FCIA), P.L. 106-169;

9. Individuals with Disabilities Education Act (IDEA), P.L. 91-230;

10. Family Education Rights Privacy Act (FERPA), 20 U.S.C. § 1232g;

11. Health Insurance Portability and Accountability Act of 1996 (HIPPA), P. L., 104-192 § 264, 42 U.S.C. § 1320d-2 (in relevant part);

12. Public Health Act, 42 U.S.C. Sec. 290dd-2 and 42 C.F.R. Part 2;

13. Louisiana Administrative Code, Title 28, Part XLIII (Bulletin 1706—Regulations for Implementation of the Children with Exceptionalities Act) and Part CI (Bulletin 1508—Pupil Appraisal Handbook).

14. Immigration laws relating to child welfare and child custody;

15. State laws and rules of evidence;
16. State laws and rules of civil procedure;
17. State laws and rules of criminal procedure;
18. State laws concerning privilege and confidentiality, public benefits, education, and disabilities;
19. State laws and rules of professional responsibility or other relevant ethics standards;
20. State laws regarding domestic violence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:322 (January 2011).

**§1109. Obligations of Counsel Regarding Parent's Rights**

A. Counsel should understand and protect the parent's rights to information and decision-making while the child is in the custody of the state. The parent's attorney shall explain to the parent what decision-making authority remains with the parent and what lies with the child welfare agency while the child is in custody of the state.

B. The parent's attorney should seek updates and reports from any service provider working with the child/family and help the client obtain information about the child's safety, health, education and well-being when the client desires.

C. Where decision-making rights remain, the parent's attorney should assist the parent in exercising his or her rights to continue to make decisions regarding the child's medical, mental health and educational services.

D. If necessary, the parent's attorney should intervene with the Office of Children and Family Services, provider agencies, medical providers and the school to ensure the parent has decision-making opportunities. This may include seeking court orders when the parent has been left out of important decisions about the child's life.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:323 (January 2011).

**§1111. Obligations of Counsel Prior to Filing of Petition**

A. Counsel, upon notice of appointment, should actively represent a parent prior to the filing of the petition in a case.

1. The parent's attorney should counsel the client about the client's rights in the investigation stage as well as the realistic pros and cons of cooperating with the Office of Children and Family Services (e.g., the parent's admissions could be used against the client later, but cooperating with services could eliminate a petition filing).

2. The parent's attorney should acknowledge that the parent may be justifiably emotional that the agency is involved with the client's family, and help the client develop strategies so the client does not express that emotion toward the caseworker in ways that may undermine the client's goals.

3. The attorney should discuss available services and help the client enroll in those in which the client wishes to participate.

4. The attorney should explore conference opportunities with the agency. If it would benefit the client, the attorney should attend any conferences. The attorney should prepare the client for issues that might arise at the conference, such as services and available kinship resources, and discuss with the client the option of bringing a support person to a conference.

5. The attorney should gather and forward to the agency the names and contact information of any potential temporary placements for the children that the client would like the agency to consider.

6. The attorney should assess whether the Office of Children and Family Services made the reasonable efforts required before removing the child from the home and the attorney should be prepared to argue a lack of reasonable efforts to the court, whenever appropriate.

B. Counsel should avoid continuances (or reduce empty adjournments) and work to reduce delays in court proceedings unless there is a strategic benefit for the client.

C. Counsel should cooperate and proactively communicate regularly with other professionals in the case, including but not limited to all agency (Office of Children and Family Services) personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:323 (January 2011).

**§1113. Counsel's Initial Interview with Client**

A. Preparing for the Initial Interview

1. Prior to conducting the initial interview the attorney should, where possible:

- a. be familiar with the allegations against the client;
- b. obtain copies of any relevant documents which are available, including copies of any reports made by law enforcement, medical personnel or Office of Children and Family Services personnel; and
- c. determine if any criminal charges have been or are likely to be filed against the client.

2. In addition, where the client is incarcerated, the attorney should:

- a. be familiar with the legal criteria for determining pretrial release and the procedures that will be followed in setting those conditions;
- b. where applicable, determine if a criminal defense attorney has been appointed regarding the related criminal charges, and develop as soon as is feasible with that attorney a joint strategy for addressing both the criminal charges and the child in need of care proceedings.

B. Conducting the Interview

1. The purpose of the initial interview is to acquire information from the client concerning the case and the client, and to provide the client with information concerning the case. Counsel should ensure at all interviews and proceedings that barriers to communication, such as differences in language or literacy, be overcome. In addition, counsel should obtain from the client all release forms necessary to obtain client's medical, psychological, education, military, prison and other records as may be pertinent.

2. Information that should be acquired from the client, such as:

- a. the facts surrounding the allegations leading to the initiation of a child in need of care proceeding, to the extent the client knows and is willing to discuss these facts;
- b. where applicable, the client's version of the removal of the child(ren); whether client was interrogated and if so, whether a statement was given; client's physical and mental status at the time the statement was given; whether any samples were provided, such as blood, tissue,

hair, DNA, handwriting, etc., and whether any scientific tests were performed on client's body or bodily fluids;

c. the name(s) and marital status of all parents of the subject child(ren) and the name of counsel for the other parents (if a conflict has been determined and counsel has been appointed or retained);

d. the names and locating information of any witnesses to the alleged abuse and/or neglect; regardless of whether these are witnesses for the prosecution or for the defense; the existence of any tangible evidence in the possession of the state and/or Office of Children and Family Services (when appropriate, counsel should take steps to insure this evidence is preserved);

e. the client's ties to the community, including the length of time he or she has lived at the current and former addresses, any prior names or aliases used, family relationships, immigration status (if applicable), employment record and history, and social security number;

f. the client's physical and mental health, educational, vocational and armed services history;

g. the client's immediate medical needs, including the need for detoxification programs and/or substance abuse treatment;

h. the client's past criminal record, if any, including arrests and convictions for adult and juvenile offenses and prior record of court appearances or failure to appear in court; the client's past involvement, if any, with a child in need of care case or the Department of Children and Family Services or, more specifically, the Office of Children and Family Services; counsel should also determine whether the client has any pending charges or outstanding warrants from other jurisdictions or agencies, whether he or she is on probation (including the nature of the probation) or parole, and the client's past or present performance under supervision;

i. the names of individuals or other sources that counsel can contact to verify the information provided by the client (counsel should obtain the permission of the client before contacting these individuals); and

j. where appropriate, evidence of the client's competence to stand trial and/or mental state at the time of the alleged abuse and/or neglect, including releases from the client for any records for treatment or testing for mental health or mental retardation.

3. Information to be provided to the client, includes, but is not limited to:

a. taking care to distinguish him or herself from others in the system so the client can see that the attorney serves the client's interests, an explanation of the attorney-client privilege and instructions not to talk to anyone about the facts of the case without first consulting with the attorney;

b. a general overview of the procedural progression of the case, the legal issues related to the case, including specific allegations against the client, the case plan, the client's rights in the pending proceeding, any orders entered against the client and the potential consequences of failing to obey court orders or cooperate with case plans, as well as the general expectations of the court and the agency, and potential consequences of the client failing to meet those expectations;

c. an explanation of the persons involved in a child in need of care case and in any subsequent termination of parental rights proceeding and the role and responsibility each person has;

d. contact information in writing and a message system that allows regular attorney-client contact. The attorney should explain that even when the attorney is unavailable, the parent should leave a message. The attorney shall respond to client messages in a reasonable time period; and

e. the names of any other persons who may be contacting the client on behalf of counsel.

4. For clients who are incarcerated:

a. communicate with the client on a regular and ongoing basis, including conferring with the client within 72 hours of being appointed and prior to every court appearance;

b. where appropriate, explain how the criminal proceedings will relate to the child in need of care and any subsequent termination of parental rights proceedings;

c. warn the client of the dangers with regard to the search of client's cell and personal belongings while in custody and the fact that telephone calls, mail, and visitations may be monitored by jail officials; and

d. assist client in obtaining services such as substance abuse treatment, parenting skills, or job training while incarcerated.

5. The parent's attorney and client should discuss timelines that reflect projected deadlines and important dates and a calendar system to remember the dates. The timeline should specify what actions the attorney and parent will need to take and dates by which they will be completed. The timeline should reflect court deadlines and Office of Children and Family Services deadlines.

6. Counsel should make available to the client copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child except when expressly prohibited by law, rule or court order. Counsel should continue throughout the proceedings to provide client all relevant documents. If the client has difficulty reading, the attorney should read the documents to the client. In all cases, the attorney should be available to discuss and explain the documents to the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:323 (January 2011).

### **§1115. Counsel's Duties Regarding Client Communication**

A. Counsel shall act in accordance with the duty of loyalty owed to the client. Attorneys representing parents should show respect and professionalism towards their clients. Parents' attorneys should support their clients and be sensitive to the client's individual needs. Attorneys should remember that they may be the client's only advocate in the system and should act accordingly.

B. Counsel shall adhere to all laws and ethical obligations concerning confidentiality. Attorneys representing parents shall understand confidentiality laws, as well as ethical obligations, and adhere to both with respect to information obtained from or about the client.

C. Counsel shall meet and communicate regularly with the client well before court proceedings.

D. Counsel should advocate for the client's goals and empower the client to direct the representation and make informed decisions.

E. Counsel should identify any potential barriers to the client's cooperation in the proceedings.

1. The parent's attorney should help the client access information about the child's developmental and other needs by speaking to service providers and reviewing the child's records. The parent needs to understand these issues to make appropriate decisions for the child's care.

2. The parent's attorney and the client should identify barriers to the client engaging in services, such as employment, transportation, housing and financial issues. The attorney should work with the client, caseworker and service provider to resolve the barriers.

3. The attorney should be aware of any special issues the parents may have related to participating in the proposed case plan, such as an inability to read or language differences, and advocate with the child welfare agency and court for appropriate accommodations.

F. Counsel should act with regard to the cultural background and socioeconomic position of the parent throughout all aspects of representation. The parent's attorney should learn about and understand the client's background, and consider how cultural and socioeconomic differences impact interaction with clients.

G. Counsel should be aware of the client's mental health status and be prepared to assess whether the parent can assist with the case in accordance with Louisiana Rule of Professional Conduct 1.14 (Client with Diminished Capacity). The attorney should be familiar with any mental health diagnosis and treatment that a client has had in the past or is presently undergoing (including any medications for such conditions). The attorney should get consent from the client to review mental health records and to speak with former and current mental health providers. The attorney should explain to the client that the information is necessary to understand the client's capacity to work with the attorney. If the client's situation seems severe, the attorney should also explain that the attorney may seek the assistance of a clinical social worker or some other mental health expert to evaluate the client's ability to assist the attorney.

H. When appointed as a curator, counsel should undertake diligent efforts to locate a missing parent, including but not limited to investigation and attempts to contact persons who may have information regarding the location of the parent. If the missing parent is found, notify him or her of the pendency and nature of the proceedings. If the missing parent is not found, the defender should stay involved throughout the case, object when necessary to preserve the missing parent's rights, and make periodic attempts to find the parent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:324 (January 2011).

#### **§1117. Counsel's Duty to Investigate**

A. Counsel has a duty to conduct a prompt, reasonable and independent investigation at every stage of the proceeding of each case. Counsel should investigate whether

the allegations of abuse and/or neglect and disposition are factually and legally correct and the client is aware of potential defenses to the allegations. The parent's attorney cannot rely solely on what the agency caseworker reports about the parent. The attorney could consider contacting service providers who work with the client, relatives who can discuss the parent's care of the child, and the child's teachers or other people who can clarify information relevant to the case.

B. Counsel should interview the client well before each hearing, in time to use client information for the case investigation. The parent's attorney should meet with the parent regularly throughout the case. The meetings should occur well before the hearing, not just at the courthouse before the case is called before the judge. The attorney should ask the client questions to obtain information to prepare the case and strive to create a comfortable environment so the client can ask the attorney questions. The attorney should use these meetings to prepare for court as well as to counsel the client concerning issues that arise during the course of the case.

C. Counsel should consider the necessity to interview the potential witnesses, including any adverse to the accused, as well as witnesses favorable to the accused. Interviews of witnesses adverse to the accused should be conducted in a manner that permits counsel to effectively impeach the witness with statements made during the interview, either by having an investigator present or, if that is not possible, by sending the investigator to conduct the interview.

D. Counsel should make efforts to secure information in the possession of the prosecution or law enforcement authorities, including police reports. Where necessary, counsel should pursue such efforts through formal and informal discovery unless sound tactical reasons exist for not doing so. Counsel should obtain National Crime Information Center or other states' criminal history records for the client and for the prosecution witnesses.

E. Where appropriate, counsel should make a prompt request to the police or investigative agency for any physical evidence or expert reports relevant to the offense or sentencing. Counsel should examine any such physical evidence.

F. Counsel should secure the assistance of experts where it is necessary or appropriate to:

1. the preparation of the defense;
2. adequate understanding of the agency's case; or
3. rebut the agency's case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:325 (January 2011).

#### **§1119. Informal Discovery**

A. The parent's attorney should review the child welfare agency case file as early during the course of representation as possible and periodically thereafter.

B. The parent's attorney should obtain all necessary documents, including copies of all pleadings and relevant notices filed by other parties, and information from the caseworker and providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:325 (January 2011).

### §1121. Formal Discovery

A. The parent's attorney should use formal discovery methods to obtain information and inspect evidence as permitted by La. Ch.C. Art. 652.

B. Counsel should consider seeking discovery, at a minimum, of the following items:

1. potential exculpatory information;
2. potential mitigating information;
3. the names and addresses of all prosecution witnesses, their prior statements, and criminal record, if any;
4. all oral and/or written statements by the accused, and the details of the circumstances under which the statements were made;
5. the prior criminal record of the accused and any evidence of other misconduct that the government may intend to use against the accused;
6. all books, papers, documents, photographs, tangible objects, buildings or places, or copies, descriptions, or other representations, or portions thereof, relevant to the case;
7. all results or reports of relevant physical or mental examinations, and of scientific tests or experiments, or copies thereof;
8. all investigative reports by all law enforcement and other agencies involved in the case; and
9. all records of evidence collected and retained by law enforcement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:326 (January 2011).

### §1123. Court Preparation

A. During investigation and trial preparation, counsel should develop and continually reassess a theory of the case and strategy to follow at hearings and negotiations.

B. Counsel for parents should engage in case planning and advocate for appropriate social services using a multidisciplinary approach to representation when available.

1. The parent's attorney should know about the social, mental health, substance abuse treatment and other services that are available to parents and families in the jurisdiction in which the attorney practices so the attorney can advocate effectively for the client to receive these services. The attorney should ask the client if the client wishes to engage in services. If so, the attorney should determine whether the client has access to the necessary services to overcome the issues that led to the case.

2. The attorney should actively engage in case planning, including attending major case meetings and family team conferences, to ensure the client asks for and receives the needed services. The attorney should also ensure the client does not agree to undesired services that are beyond the scope of the case.

3. Whenever possible, the parent's attorney should engage or involve a social worker as part of the parent's "team" to help determine an appropriate case plan, evaluate social services suggested for the client, and act as a liaison and advocate for the client with the service providers.

C. Counsel for parents should research applicable legal issues and advance legal arguments when appropriate.

D. Counsel for parents shall timely file all appropriate pleadings, motions, and briefs.

1. Counsel should consider filing an appropriate motion whenever there exists a good-faith reason to believe

that the parent is entitled to relief which the court has discretion to grant.

2. The decision to file pretrial motions should be made after considering the applicable law in light of the known circumstances of each case.

3. Among the issues that counsel should consider addressing in a pretrial motion are:

- a. the constitutionality of the implicated statute or statutes;
- b. the potential defects in the charging process;
- c. the sufficiency of the charging documents;
- d. the discovery obligations of the prosecution/agency and the reciprocal discovery obligations of the defense; and
- e. access to resources which, or experts, who may be denied to an accused because of his or her indigence.

E. Counsel for parents should aggressively advocate for regular visitation in a family-friendly setting. Factors to consider in visiting plans include:

1. frequency;
2. length;
3. location;
4. supervision;
5. types of activities; and
6. visit coaching—having someone at the visit who could model effective parenting skills.

F. With the client's permission, and when appropriate, counsel for parents should engage in settlement negotiations and mediation to resolve the case. Counsel should adhere to all laws and ethical obligations concerning confidentiality and participate in such proceedings in good faith.

1. Counsel should keep the client fully informed of any continued discussion concerning stipulating and related negotiations and promptly convey to the accused any offers made by the prosecution/agency for a negotiated settlement.

2. Counsel shall not accept any stipulation agreement without the client's express authorization. Prior to entering any stipulation, counsel should ensure that client understands the potential consequences of certain stipulations, particularly the potential for a subsequent termination of parental rights.

3. The existence of ongoing tentative stipulation negotiations with the prosecution/agency should not prevent counsel from taking steps necessary to preserve a defense nor should the existence of ongoing stipulation negotiations prevent or delay counsel's investigation into the facts of the case and preparation of the case for further proceedings, including trial.

4. In order to develop an overall negotiation plan, counsel should be aware of, and make sure the client is aware of:

- a. the conditions proposed by the Office of Children and Family Services;
- b. the spectrum of possible outcomes;
- c. other consequences of adjudication, including but not limited to the impact on any potential criminal investigation or subsequent termination of parental rights proceeding;
- d. concessions that the client might offer the prosecution as part of a negotiated settlement, including, but not limited to:
  - i. not to proceed to adjudication;

- ii. decline from asserting or litigating any particular pretrial motions; and
- iii. an agreement to fulfill specified, written conditions; and
- e. benefits the client might obtain from a negotiated settlement, including, but not limited to an agreement:
  - i. to enter into an informal adjustment agreement;
  - ii. reunification with particular conditions;
  - iii. to dismiss or reduce one or more charged criminal offenses either immediately, or upon completion of a deferred prosecution agreement; and
  - iv. that the respondent will not be subject to further investigation or prosecution for uncharged alleged criminal conduct.

5. In conducting stipulation negotiations, counsel should be familiar with:

- a. the advantages and disadvantages of stipulation according to the circumstances of the case; and
- b. the various types of stipulations that may be agreed to, including but not limited to a stipulation without admitting the allegations.

6. In conducting negotiations, counsel should attempt to become familiar with the practices and policies of the particular jurisdiction, judge and prosecuting authority, and Office of Children and Family Services personnel which may affect the content and likely results of negotiated agreements.

G. Counsel for parents should thoroughly prepare the client to testify at the hearing;

H. Counsel for parents should identify, locate and prepare all witnesses; and

I. Counsel for parents should identify, secure, prepare and qualify expert witness when needed. When permissible, counsel should interview opposing counsel's experts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:326 (January 2011).

**§1125. Entering the Negotiated Stipulation before the Court**

A. Prior to the entry of a stipulation, counsel should:

- 1. make certain that the client understands the rights he or she will waive by entering the stipulation and that the client's decision to waive those rights is knowing, voluntary and intelligent;
- 2. make certain that the client receives a full explanation of the conditions and limits of the stipulation and the potential outcomes and collateral consequences the client will be exposed to by entering a stipulation; and
- 3. explain to the client the nature of the stipulation and prepare the client for the role he or she will play in the proceeding, including answering questions of the judge and, where appropriate, providing a statement concerning the allegations.

B. When entering the stipulation, counsel should make sure that the full content and conditions of the stipulation agreement are placed on the record before the court.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:327 (January 2011).

**§1127. Counsel's Duties at Continued Custody Hearing**

A. At the continued custody hearing, counsel for a parent should take steps to see that the hearing is conducted in a timely fashion pursuant to La. Ch. C. Art. 624, unless there are strategic reasons for not doing so.

B. In preparing for the continued custody hearing, the attorney should become familiar with:

- 1. the alleged abuse and/or neglect;
- 2. the law of establishing grounds of abuse and neglect (La. Ch. C. Art. 606);
- 3. the requirement that the department made reasonable efforts to prevent or eliminate the need for the child(ren)'s removal before taking custody of the child(ren); and
- 4. the subpoena process for obtaining compulsory attendance of witnesses at the continued custody hearing and the necessary steps to be taken in order to obtain a proper recordation of the proceedings.

C. Counsel for a parent should be prepared, in keeping with an overall case strategy, to present reasonable terms of return/reunification of children, with potential conditions, at the continued custody phase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:327 (January 2011).

**§1129. Counsel's Duty of Preparation for Adjudication**

A. Where appropriate, counsel should have the following materials available at the time of adjudication:

- 1. copies of all relevant documents filed in the case;
- 2. relevant documents prepared by investigators;
- 3. cross-examination plans for all possible prosecution witnesses;
- 4. direct examination plans for all prospective defense witnesses;
- 5. copies of defense subpoenas;
- 6. prior statements of all prosecution witnesses (e.g., transcripts, police reports) and counsel should have prepared transcripts of any audio or video taped witness statements;
- 7. prior statements of all defense witnesses;
- 8. reports from defense experts;
- 9. a list of all defense exhibits, and the witnesses through whom they will be introduced;
- 10. originals and copies of all documentary exhibits; and
- 11. copies of all relevant statutes and cases.

B. Counsel should be fully informed as to the rules of evidence, court rules, and the law relating to all stages of the adjudication process, and should be familiar with legal and evidentiary issues that can reasonably be anticipated to arise at adjudication.

C. Counsel should request the opportunity to make opening and closing arguments. When permitted by the judge, counsel should make opening and closing arguments to best present the theory of the case.

D. Counsel should decide if it is beneficial to secure an advance ruling on issues likely to arise at trial (e.g., use of prior convictions to impeach the defendant) and, where appropriate, counsel should prepare motions and memoranda for such advance rulings.

E. Throughout the adjudication process counsel should endeavor to establish a proper record for appellate review. Counsel shall be familiar with the substantive and procedural law regarding the preservation of legal error for appellate review, and should insure that a sufficient record is made to preserve appropriate and potentially meritorious legal issues for such appellate review unless there are strategic reasons for not doing so.

F. Where appropriate, counsel should advise the client as to suitable courtroom dress and demeanor. If the client is incarcerated, if necessary, counsel should consider filing pre-trial motions to insure that the client has appropriate clothing.

G. Counsel should plan with the client the most convenient system for conferring throughout the adjudication hearing. Where necessary, counsel should seek a court order to have the client available for conferences.

H. Counsel should prepare proposed findings of fact, conclusions of law, and orders when they will be used in the court's decision or may otherwise benefit the client.

I. Counsel shall take necessary steps to insure full official recordation of all aspects of the court proceeding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:327 (January 2011).

### **§1131. Right to Closed Proceedings (or a Cleared Courtroom)**

A. In accordance with La. Ch.C. Art. 407, the parent's attorney should be aware of who is in the courtroom during a hearing and should request the courtroom be cleared of individuals not related to the case when appropriate.

B. The attorney should be attuned to the client's comfort level with people outside of the case hearing about the client's family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:328 (January 2011).

### **§1133. Preparation for Challenging the Prosecution's/Agency's Case**

A. Counsel should attempt to anticipate weaknesses in the prosecution's case and consider researching and preparing corresponding motions to dismiss.

B. Counsel should consider the advantages and disadvantages of entering into factual stipulations concerning the prosecution's case.

C. In preparing for cross-examination, counsel should be familiar with the applicable law and procedures concerning cross-examinations and impeachment of witnesses. In order to develop material for impeachment or to discover documents subject to disclosure, counsel should be prepared to question witnesses as to the existence of prior statements which they may have made or adopted.

D. In preparing for cross-examination, counsel should:

1. consider the need to integrate cross-examination, the theory of the defense and closing argument;
2. consider whether cross-examination of each of the individual witnesses is likely to generate helpful information;
3. anticipate those witnesses the prosecution might call in its case-in-chief or in rebuttal;

4. consider a cross-examination plan for each of the anticipated witnesses;

5. be alert to inconsistencies in a witnesses' testimony;

6. be alert to possible variations in witnesses' testimony;

7. review all prior statements of the witnesses and any prior relevant testimony of the prospective witnesses;

8. have prepared a transcript of all audio or video tape recorded statements made by the witnesses;

9. where appropriate, review relevant statutes and local police policy and procedure manuals, disciplinary records and department regulations for possible use in cross-examining police witnesses;

10. be alert to issues relating to witnesses' credibility, including bias and motive for testifying; and

11. have prepared, for introduction into evidence, all documents which counsel intends to use during the cross-examination, including certified copies of records such as prior convictions of the witnesses or prior sworn testimony of the witnesses.

E. Counsel should consider conducting a voir dire examination of potential prosecution witnesses who may not be competent to give particular testimony, including expert witnesses whom the prosecutor may call. Counsel should be aware of the applicable law of the jurisdiction concerning competency of witnesses in general and admission of expert testimony in particular in order to be able to raise appropriate objections.

F. Before beginning cross-examination, counsel should ascertain whether the prosecutor has provided copies of all prior statements of the witnesses as required by applicable law. If counsel does not receive prior statements of prosecution witnesses until they have completed direct examination, counsel should request adequate time to review these documents before commencing cross-examination.

G. Where appropriate, at the close of the prosecution's case, counsel should move for a finding that the child is not in need of care. Counsel should request, when necessary, that the court immediately rule on the motion, in order that counsel may make an informed decision about whether to present a defense case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:328 (January 2011).

### **§1135. Presenting the Respondent's Case**

A. Counsel should develop, in consultation with the client, an overall defense strategy. In deciding on defense strategy, counsel should consider whether the client's interests are best served by not putting on a defense case, and instead relying on the prosecution's failure to meet its burden of proving its case by a preponderance of the evidence.

B. Counsel should discuss with the client all of the considerations relevant to the client's decision to testify. Counsel should also be familiar with his or her ethical responsibilities that may be applicable if the client insists on testifying untruthfully. Counsel should explain to the client the constitutional right to not testify and weigh the value of doing so with the client.

C. In preparing for presentation of a defense case, counsel should, where appropriate:

1. develop a plan for direct examination of each potential defense witness;
2. determine the implications that the order of witnesses may have on the defense case;
3. determine what facts necessary for the defense case can be elicited through the cross-examination of the prosecution's witnesses;
4. consider the possible use of character witnesses;
5. consider the need for expert witnesses and what evidence must be submitted to lay the foundation for the expert's testimony;
6. review all documentary evidence that must be presented; and
7. review all tangible evidence that must be presented.

D. In developing and presenting the defense case, counsel should consider the implications it may have for a rebuttal by the prosecutor.

E. Counsel should prepare all witnesses for direct and possible cross-examination. Where appropriate, counsel should also advise witnesses of suitable courtroom dress and demeanor.

F. Counsel should conduct redirect examination as appropriate.

G. At the close of the defense case, counsel should renew the motion for a finding that the child is not in need of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

#### **§1137. Obligations of Counsel at Disposition Hearing**

A. Counsel for a parent, regarding the disposition process, should:

1. where a respondent chooses not to proceed to adjudication, ensure that a stipulation agreement is negotiated with consideration of the dispositional implications;
2. ensure the client is not harmed by inaccurate information or information that is not properly before the court in determining the disposition;
3. ensure all reasonably available mitigating and favorable information, which is likely to benefit the client, is presented to the court; and
4. develop a plan which seeks to achieve the least restrictive and burdensome disposition that is most acceptable to the client, and which can reasonably be obtained based on the facts and circumstances of the case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

#### **§1139. Preparation for Disposition**

A. In preparing for disposition, counsel should consider the need to:

1. inform the client of the dispositional alternatives, and the likely and possible consequences of those alternatives;
2. maintain regular contact with the client prior to the disposition hearing, and inform the client of the steps being taken in preparation for same;
3. obtain from the client relevant information concerning such subjects as his or her background and

personal history, prior criminal record, employment history and skills, education, medical history and condition, financial status, family obligations, and sources through which the information provided can be corroborated;

4. inform the client of his or her right to testify at the disposition hearing and assist the client in preparing the testimony, if any, to be made to the court, considering the possible consequences that any admission of guilt may have upon an appeal;

5. inform the client of the effects that admissions and other statements may have upon an appeal, termination of parental rights proceedings, or other judicial proceedings, such as criminal proceedings; and

6. collect documents and affidavits to support the defense position and, where relevant, prepare witnesses to testify at the disposition hearing; where necessary, counsel should specifically request the opportunity to present tangible and testimonial evidence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

#### **§1141. The Prosecution's Position at Disposition**

A. Counsel should attempt to determine, unless there is a sound tactical reason for not doing so, whether the prosecution/agency will advocate that a particular disposition be imposed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

#### **§1143. The Disposition Process**

A. Counsel should be prepared at the disposition hearing to take the steps necessary to advocate fully for the requested disposition and to protect the client's interest.

B. In the event there will be disputed facts before the court at the disposition hearing, counsel should be prepared to present evidence, including testimony of witnesses, to contradict erroneous or misleading information unfavorable to the defendant.

C. Where information favorable to the defendant will be disputed or challenged, counsel should be prepared to present supporting evidence, including testimony of witnesses, to establish the facts favorable to the defendant.

D. Where appropriate, counsel should prepare the client to personally address the court.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

#### **§1145. Termination of Parental Rights Proceedings**

A. Counsel should be aware of and advise the client of the gravity and potential permanent effects of a termination of parental rights petition. A termination of parental rights ruling has a serious impact as the parent can lose all rights to visitation, custody, and contact with the child. Counsel should treat any termination hearings with the respect, dedication, and commitment such a serious matter deserves.

B. Counsel should meet or exceed the standards set forth below.

1. Preparation for termination of parental rights hearing:

a. where appropriate, counsel should have the following materials available at the time of the termination hearing:

- i. copies of all relevant documents filed in the case;
- ii. relevant documents prepared by investigators;
- iii. cross-examination plans for all possible prosecution witnesses;
- iv. direct examination plans for all prospective defense witnesses;
- v. copies of defense subpoenas;
- vi. prior statements of all prosecution witnesses (e.g., transcripts, police reports) and counsel should have prepared transcripts of any audio or video-taped witness statements;
- vii. prior statements of all defense witnesses;
- viii. reports from defense experts;
- ix. a list of all defense exhibits, and the witnesses through whom they will be introduced;
- x. originals and copies of all documentary exhibits; and
- xi. copies of all relevant statutes and cases;

b. counsel should be fully informed as to the rules of evidence, court rules, and the law relating to all stages of the termination process, and should be familiar with legal and evidentiary issues that can reasonably be anticipated to arise at termination hearings;

c. counsel should request the opportunity to make opening and closing arguments. When permitted by the judge, counsel should make opening and closing arguments to best present the theory of the case;

d. counsel should decide if it is beneficial to secure an advance ruling on issues likely to arise at trial (e.g., use of prior convictions to impeach the defendant) and, where appropriate, counsel should prepare motions and memoranda for such advance rulings;

e. throughout the termination hearing process, counsel should endeavor to establish a proper record for appellate review. Counsel shall be familiar with the substantive and procedural law regarding the preservation of legal error for appellate review, and should insure that a sufficient record is made to preserve appropriate and potentially meritorious legal issues for such appellate review unless there are strategic reasons for not doing so;

f. where appropriate, counsel should advise the client as to suitable courtroom dress and demeanor. If the client is incarcerated, if necessary, counsel should consider filing pre-trial motions to insure that the client has appropriate clothing;

g. counsel should plan with the client the most convenient system for conferring throughout the termination hearing. Where necessary, counsel should seek a court order to have the client available for conferences;

h. counsel should prepare proposed findings of fact, conclusions of law, and orders when they will be used in the court's decision or may otherwise benefit the client;

i. counsel shall take necessary steps to insure full official recordation of all aspects of the court proceeding.

## 2. Right to Closed Proceedings (or a Cleared Courtroom)

a. In accordance with La. Ch.C. Art. 407, the parent's attorney should be aware of who is in the courtroom

during a hearing and should request the courtroom be cleared of individuals not related to the case when appropriate.

b. The attorney should be attuned to the client's comfort level with people outside of the case hearing about the client's family.

## 3. Preparation for Challenging the Prosecution's/Agency's Case

a. Counsel should attempt to anticipate weaknesses in the prosecution's proof and consider researching and preparing corresponding motions for judgment denying termination of parental rights.

b. Counsel should consider the advantages and disadvantages of entering into factual stipulations concerning the prosecution's case.

c. In preparing for cross-examination, counsel should be familiar with the applicable law and procedures concerning cross-examinations and impeachment of witnesses. In order to develop material for impeachment or to discover documents subject to disclosure, counsel should be prepared to question witnesses as to the existence of prior statements which they may have made or adopted.

d. In preparing for cross-examination, counsel should:

- i. consider the need to integrate cross-examination, the theory of the defense and closing argument;
- ii. consider whether cross-examination of each of the individual witnesses is likely to generate helpful information;

- iii. anticipate those witnesses the prosecutor might call in its case-in-chief or in rebuttal;

- iv. consider a cross-examination plan for each of the anticipated witnesses;

- v. be alert to inconsistencies in witness testimony;
- vi. be alert to possible variations in witness testimony;

- vii. review all prior statements of the witnesses and any prior relevant testimony of the prospective witnesses;

- viii. have prepared a transcript of all audio or video tape recorded statements made by the witnesses;

- ix. where appropriate, review relevant statutes and local police policy and procedure manuals, disciplinary records and department regulations for possible use in cross-examining police witnesses;

- x. be alert to issues relating to witness credibility, including bias and motive for testifying; and

- xi. have prepared, for introduction into evidence, all documents which counsel intends to use during the cross-examination, including certified copies of records such as prior convictions of the witness or prior sworn testimony of the witness.

e. Counsel should consider conducting a voir dire examination of potential prosecution witnesses who may not be competent to give particular testimony, including expert witnesses whom the prosecutor may call. Counsel should be aware of the applicable law of the jurisdiction concerning competency of witnesses in general and admission of expert testimony in particular in order to be able to raise appropriate objections.

f. Before beginning cross-examination, counsel should ascertain whether the prosecutor has provided copies of all prior statements of the witnesses as required by

applicable law. If counsel does not receive prior statements of prosecution witnesses until they have completed direct examination, counsel should request adequate time to review these documents before commencing cross-examination.

g. Where appropriate, at the close of the prosecution's case, counsel should move for a judgment upholding the parental rights of the client. Counsel should request, when necessary, that the court immediately rule on the motion, in order that counsel may make an informed decision about whether to present a defense case.

#### 4. Presenting the Respondent's Case

a. Counsel should develop, in consultation with the client, an overall defense strategy. In deciding on defense strategy, counsel should consider whether the client's interests are best served by not putting on a defense case, and instead relying on the prosecution's failure to meet its burden of proving its case by a preponderance of the evidence.

b. Counsel should discuss with the client all of the considerations relevant to the client's decision to testify. Counsel should also be familiar with his or her ethical responsibilities that may be applicable if the client insists on testifying untruthfully. Counsel should explain to the client the constitutional right to not testify and weigh the value of doing so with the client.

c. In preparing for presentation of a defense case, counsel should, where appropriate:

i. develop a plan for direct examination of each potential defense witness;

ii. determine the implications that the order of witnesses may have on the defense case;

iii. determine what facts necessary for the defense case can be elicited through the cross-examination of the prosecution's witnesses;

iv. consider the possible use of character witnesses;

v. consider the need for expert witnesses and what evidence must be submitted to lay the foundation for the expert's testimony;

vi. review all documentary evidence that must be presented; and

vii. review all tangible evidence that must be presented.

d. In developing and presenting the defense case, counsel should consider the implications it may have for a rebuttal by the prosecutor.

e. Counsel should prepare all witnesses for direct and possible cross-examination. Where appropriate, counsel should also advise witnesses of suitable courtroom dress and demeanor.

f. Counsel should conduct redirect examination as appropriate.

g. At the close of the defense case, counsel should renew the motion for a judgment upholding the parental rights of the client.

C. Whenever appropriate, counsel should consider an appeal of an unfavorable verdict.

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HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:329 (January 2011).

### **§1147. Review Court Orders to Ensure Accuracy and Clarity and Review with Client**

A. After any hearing, the parent's attorney should review the written order to ensure it reflects the court's verbal order.

B. If the order is incorrect, the attorney should take whatever steps are necessary to correct it.

C. Once the order is final, the parent's attorney should provide the client with a copy of the order and should review the order with the client to ensure the client understands it. If the client is unhappy with the order, the attorney should counsel the client about any options to appeal or request rehearing on the order, but should explain that the order is in effect unless a stay or other relief is secured. The attorney should counsel the client on the potential consequences of failing to comply with a court order.

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HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:331 (January 2011).

### **§1149. Motion for Rehearing**

A. Counsel should be familiar with the procedures available to request a rehearing including the time period for filing such a motion, the effect it has upon the time to file a notice of appeal, and the grounds that can be raised.

B. When the court has adjudicated the subject child(ren) a child in need of care or has ordered a termination of parental rights, counsel should consider whether it is appropriate to file a motion for rehearing with the trial court. In deciding whether to file such a motion, the factors counsel should consider include:

1. the likelihood of success of the motion, given the nature of the error or errors that can be raised; and

2. the effect that such a motion might have upon the respondent's appellate rights, including whether the filing of such a motion is necessary to, or will assist in, preserving the respondent's right to raise on appeal the issues that might be raised in the new trial motion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:331 (January 2011).

### **§1151. Take Reasonable Steps to Ensure the Client Complies with Court Orders**

A. The parent's attorney should answer the parent's questions about obligations under the order and periodically check with the client to determine the client's progress in implementing the order.

B. If the client is attempting to comply with the order but other parties, such as the child welfare agency, are not meeting their responsibilities, the parent's attorney should approach the other party and seek assistance on behalf of the client.

C. If necessary, the attorney should bring the case back to court to review the order and the other party's noncompliance or take other steps to ensure that appropriate social services are available to the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:331 (January 2011).

**§1153. Consider and Discuss the Possibility of Appeal with the Client**

A. The parent's attorney should consider and discuss with the client the possibility of appeal when a court's ruling is contrary to the client's position or interests.

B. The attorney should counsel the client on the likelihood of success on appeal and potential consequences of an appeal.

C. The attorney shall also comply with all ethical rules and rules of courts of appeal concerning the attorney's determination that there is a reasonable basis for the appeal.

D. Depending on rules in the attorney's jurisdiction, the attorney should also consider filing an extraordinary writ or motions for other post-hearing relief.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:332 (January 2011).

**§1155. Appeals**

A. If the client decides to appeal, counsel should timely and thoroughly file the necessary post-hearing motions and paperwork related to the appeal and closely follow the jurisdiction's rules of appellate procedure.

B. The appellate brief should be clear, concise, and comprehensive and also timely filed. The brief should reflect all relevant case law and present the best legal arguments available in state and federal law for the client's position. The brief should include novel legal arguments if there is a chance of developing favorable law in support of the parent's position.

C. If oral arguments are scheduled, the attorney should be prepared, organized, and direct. Appellate counsel should inform the client of the date, time and place scheduled for oral argument of the appeal upon receiving notice from the appellate court. Oral argument of the appeal on behalf of the client should not be waived, absent the express approval of the client, unless doing so would benefit the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:332 (January 2011).

**§1157. Expedited Appeals**

A. The attorney should request an expedited appeal, when feasible, and file all necessary paperwork while the appeal is pending.

B. The attorney should provide information about why the case should be expedited, such as any special characteristics about the child and why delay would harm the relationship between the parent and child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:332 (January 2011).

**§1159. Communication with Client Pending and After Appeal**

A. The parent's attorney should communicate the result of the appeal and its implications.

B. The parent's attorney should provide the client with a copy of the appellate decision.

C. If, as a result of the appeal, the attorney needs to file any motions with the trial court, the attorney should do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:148.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Public Defender Board, LR 37:332 (January 2011).

Jean M. Faria  
State Public Defender

1101#044

**RULE**

**Office of the Governor  
Real Estate Appraisers Board**

Appraisers (LAC 46:LXVII.Chapters 103-105)

Under the authority of the Louisiana Real Estate Appraisers Law, R.S. 37:3391 et seq., and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950, et seq., the Louisiana Real Estate Appraisers Board has amended LAC 46:LXVII.Chapters 103-105.

With the exception of Sections 10311 and 10313, the amendments can all be considered housekeeping in nature, in that they serve to organize, clarify, or better explain the existing rule requirements. Sections 10311 and 10313 has been amended based on guidelines from the federal Appraiser Qualification Board (AQB). These Sections are relative to earned experience credits, which have been converted by the proposed action from a "point" system to an "hours" system.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part LXVII. Real Estate**

**Subpart 2. Appraisers**

**Chapter 103. License Requirements**

**§10301. Applications**

A. - D. ...

E. A nonresident real property appraiser licensed in another state, commonwealth, or territory shall submit a completed application form and fees prescribed by the board, including an irrevocable consent to service of process in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1332 (June 2005), amended LR 37:332 (January 2011).

**§10303. Examination**

A. ...

B. Any applicant who fails an examination may apply to retake the examination by submitting a copy of the fail notice and a new examination processing fee to the board. After one year, the applicant shall be required to submit a new application and remit all prescribed fees to be eligible for the licensing examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of

Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1332 (June 2005), amended LR 37:332 (January 2011).

**§10307. Education Requirements**

A. - B. ...

C. A certified residential or certified general appraiser shall complete the course *Supervising Appraiser Trainee*, or an equivalent course approved by the board, prior to sponsoring an appraiser trainee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), amended LR 37:333 (January 2011).

**§10308. Appraiser Trainees**

A. The scope of work for the appraiser trainee shall be limited to the appraisal of those properties that the supervising appraiser is licensed to appraise.

B. A trainee shall not perform any appraisals under the supervision of a licensed appraiser whose license has been suspended or revoked.

C. A certified residential or certified general real property appraiser may engage a licensed appraiser trainee to assist in the performance of real estate appraisals, provided the certified appraiser meets the following criteria:

1. has been licensed in good standing with the board for at least two full years;
2. has no more than three trainees working under his/her supervision at any one time, either as employees or subcontractors;
3. agrees to supervise the licensed appraiser trainee's work product, as specified below, subject to the guidelines and requirements of the Uniform Standards of Professional Appraisal Practice, and be responsible for the trainee's conduct.

a. Supervision implies that the supervisor will not sign or endorse an appraisal report that was not substantially produced by the appraiser trainee. The term substantial means that the trainee contributed materially and in a verifiable manner to the research and/or analysis that led to the final opinion of value expressed in the appraisal.

4. The supervising appraiser shall accompany the licensed appraiser trainee on inspections of the subject property until the supervising appraiser feels the appraiser trainee is competent to do so.

5. The supervising appraiser shall make available to the trainee a copy of every appraisal report wherein the trainee has provided substantial professional assistance in the preparation of the report as defined above.

6. The supervising appraiser shall sign every appraisal report prepared by the trainee who acts under the supervising appraiser's supervision.

7. The supervising appraiser shall immediately notify the board and the trainee in writing of any termination of supervision of a licensed appraiser trainee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), amended LR 37:333 (January 2011).

**§10309. Application for Experience Credit**

A. - C. ...

D. Applicants may submit appraisals to the peer review committee for review prior to submission of the application for experience credit.

E. Only those real property appraisals consistent with the Uniform Standards of Professional Appraisal Practice will be accepted by the board for experience credit.

F. The board may require an applicant to successfully complete additional educational training consisting of not less than 15 or more than 30 instructional hours of course work approved by the board, which shall not be used to satisfy the continuing education requirement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1426 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), amended LR 37:333 (January 2011).

**§10311. Residential Experience Requirements**

A. A minimum of 3500 hours of appraisal experience in no fewer than 24 months is required. The maximum allowable credit that shall be applied toward the experience requirement in a 12-month period is 1750 hours.

A.1. - B. ...

C. At least 1750 hours of appraisal experience shall come from the development of appraisals reported in self contained or summary reports.

D. Residential experience credit hours shall be limited as follows.

1. One unit dwelling (house, townhouse, condominium)	8 hours
2. Two to four unit dwelling (apartment, duplex, condominium)	10 hours
3. Residential lot (1 2- 4 family)	6 hours
4. Residential subdivision sites	8 hours
5. Farm or timber acreage suitable for a house site	8 hours
6. Rural residence-one unit primary dwelling—10 acres or less	10 hours
7. Ranchette—part-time rural use—10 to 25 acres—with main dwelling and outbuildings, such as additional residence, barns, and/or other outbuildings	10 hours
8. All other unusual structures or acreage—larger or more complex than typical properties described herein—hours to be determined by board upon submission	12 hours
9. Review of appraisals shall be worth 50 percent of the hours awarded for the appraisal (not to exceed 350 hours per year or 1750 hours in total)	

E. - F.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1426 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board of Certification, LR 29:126 (February 2003), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1334 (June 2005), amended LR 37:333 (January 2011).

**§10313. General Experience Requirements**

A. A minimum of 5000 hours of appraisal experience in no fewer than 36 months is required. The maximum allowable credit that shall be applied toward the experience requirement in a 12-month period is 1700 hours.

1. When an appraisal report is signed by more than one trainee, credit for said assignment must be divided equally. For the purpose of granting credit, a person signing in the capacity of a review or supervisory appraiser is not considered as a co-signer on the report, provided that his or her role as such is clearly indicated in the report.

2. ...

B. A maximum of 1000 hours of residential experience credit hours may be applied toward the total hours required for a certified general real property appraiser license.

C. At least 2500 hours of appraisal experience shall come from the development of appraisals reported in self contained or summary format. These reports shall include a direct sales approach, cost data approach, and income data approach.

D. General experience credit hours shall be limited as follows.

1. Apartments 20 units or less over 20 units	40 hours 80 hours
2. Hotels/motels	85 hours
3. Nursing home/assisted living facilities	85 hours
4. Industrial/warehouse properties	80 hours
5. Office/medical buildings Single tenant or owner occupied Multiple tenant	40 hours 80 hours
6. Condominiums complexes	85 hours
7. Retail properties Single tenant or owner occupied Multiple tenant	40 hours 80 hours
8. Commercial or multi-family tracts	40 hours
9. Ranch – pasture or grazing usage	40 hours
10. Agricultural land	40 hours
11. Dairy or poultry farms	40 hours
12. Timberland appraisals	40 hours
13. Specialized properties	Submit to board for determination
14. No more than 40 percent of the cumulative hours may be earned from any one property type category.	
15. Review of appraisals shall be worth 50 percent of the hours awarded for the appraisal. No more than 2500 hours total shall be from reviews.	

E. - E.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1427 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board of Certification, LR 29:126 (February 2003), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1334 (June 2005), amended LR 37:333 (January 2011).

**§10315. Appraisal Review Requirements**

A. - B.4. ...

C. No more than 50 percent of experience credit hours shall be awarded for review of appraisals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1428 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1335 (June 2005), amended LR 37:334 (January 2011).

**Chapter 104. Education Providers/Course Approval  
§10403. Approval of Qualifying/Continuing Education Courses**

A. Education providers shall apply directly to the board for qualifying and continuing education course approval. Application forms will be provided by the board. Information to be submitted for each course offering shall include:

1. - 7. ...

B. Any request for additional course approval from an approved education provider shall be approved by the board prior to the course presentation.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1429 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1336 (June 2005), amended LR 37:334 (January 2011).

**§10407. Qualifying Education**

A. A class hour is defined as 60 minutes, of which at least 50 minutes shall be instruction attended by the student. The prescribed number of class hours includes time for examinations.

B. Courses taken to satisfy the qualifying education requirement shall be granted only where the minimum length of the course is at least 15 instructional hours and successful completion of a final examination pertinent to that educational offering is required.

C. ...

D. Distance education is defined as any education process based on the geographical separation of student and instructor. A distance education course shall be acceptable to meet class hour requirements if:

1. the course provides a reciprocal environment where the student has an appropriate level of verbal or written communication with the instructor; and

2. one of the following requirements is met:

a. the course shall be presented by an accredited college, community or junior college (Commission on Colleges, regional or national accreditation association), or university that offers distance education programs; or

b. the course shall have received approval from the International Distance Education Certification Center (IDECC) for the course design and delivery method, and either:

D.2.b.i. - ii. ...

E. Courses taken to satisfy the qualifying education requirement shall not be repetitive. USPAP courses taken in different years are not considered repetitive. Courses shall foster problem-solving skills in the education process by utilizing case studies as a major teaching method when applicable.

F. Applicants shall take the 15-Hour National USPAP Course, or its equivalent, and pass the associated 15-Hour National USPAP Course Examination. The course instructor shall be an AQB Certified USPAP Instructor who is also a state certified real property appraiser. Course equivalency shall be determined through the AQB Course Approval

Program or by an alternate method established by the AQB. USPAP education presented in a distance education format shall be designed to foster appropriate student to instructor interaction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1429 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1336 (June 2005), amended LR 37:334 (January 2011).

#### **§10409. Continuing Education**

A. The purpose of continuing education is to ensure that appraisers participate in a program that maintains and increases their skill, knowledge, and competency in real property appraising.

B. Credit towards the continuing education hour requirements for each appraiser classification will be granted only where the length of the educational offering is at least two hours.

C. Credit will be granted for education offerings that are consistent with the purpose of continuing education and cover those real estate appraisal topics, including, but not limited to:

C.1. - C.16. ...

D. Up to one half of the continuing education requirement may also be granted for instruction of any approved course or seminar. Credit for instructing any approved course or seminar shall only be awarded once during a continuing education cycle.

E. ...

F. In addition to the requirements described in §10407.D, distance education courses intended for use as continuing education shall include at least one of the following:

1. ...

2. the student successfully completes prescribed materials required to demonstrate knowledge of the subject matter.

G. Real estate appraisal related field trips may be acceptable for credit toward the continuing education requirements; however, transit time to or from the field trip shall not be included when awarding credit unless instruction occurs during said transit time.

H. Appraisers shall successfully complete the seven-hour National USPAP Update Course, or its equivalent every two calendar years. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1430 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1337 (June 2005), amended LR 37:335 (January 2011).

#### **§10411. Instructor Qualifications**

A. - A.5. ...

B. Instructors for continuing education courses shall satisfy at least one of the following qualification requirements:

1. - 4. ...

C. Instructors of the 15-hour National USPAP Course and seven-hour National USPAP Update Course shall be certified by the Appraiser Qualifications Board (AQB) and hold a current license as a state certified real appraiser.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisal Board of Certification, LR 25:1430 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1338 (June 2005), amended LR 37:335 (January 2011).

#### **§10413. Americans with Disabilities Act (ADA)**

##### **Compliance**

A. For purposes of meeting the requirements of the Americans with Disabilities Act (ADA), the board may permit an alternative method of course delivery other than the regular method of presentation. Verification of the disability of the individual requiring completion of the course work through an alternative delivery method may be required by the board prior to granting such a request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisal Board of Certification, LR 25:1431 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1338 (June 2005), amended LR 37:335 (January 2011).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisal Board of Certification, LR 25:1431 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1338 (June 2005), amended LR 37:335 (January 2011).

#### **§10415. Americans with Disabilities Act (ADA)**

##### **Compliance**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisal Board of Certification, LR 25:1431 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1338 (June 2005), repealed LR 37:335 (January 2011).

#### **Chapter 105. Investigations and Adjudicatory Proceedings**

##### **§10507. Adjudicatory Proceedings**

A. - A.1.k. ...

1. The actions of the board relative to all consent orders shall be noted in the minutes of the meeting at which the consent order is considered and authorization is granted to the executive director to execute the order in the name of the board.

2. - 2.d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisal Board of Certification, LR 25:1432 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1338 (June 2005), amended LR 37:335 (January 2011).

Bruce Unangst  
Chairman

1101#056

## RULE

### Department of Health and Hospitals Board of Medical Examiners

Enforcement Terms; Unprofessional Conduct  
(LAC 46:XLV.7601-7605)

The Louisiana State Board of Medical Examiners, pursuant to the authority of the Louisiana Medical Practice Act, R.S. 37:1261-1292, and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., has amended its administrative rules governing physician practice, LAC 46:XLV, Subpart 3 (Practice), by adopting Subchapter 76, §§7601-7605 (Definition of Enforcement Terms). The rules are set forth below.

#### Title 46

### PROFESSIONAL AND OCCUPATIONAL STANDARDS

#### Part XLV. Medical Professions

##### Subpart 3. Practice

#### Chapter 76. Definition of Enforcement Terms

##### Subchapter A. General Provisions

#### §7601. Scope of Chapter

A. The board has the responsibility to consider and determine action upon all charges of conduct which fail to conform to the Louisiana Medical Practice Act, R.S. 37:1261-1292 et seq., as re-enacted and amended, and the rules and regulations promulgated by the board to carry out the provisions of this Part. The rules of this Chapter compliment the board's authority to deny, suspend, revoke or take such other action against a physician's license, as it may determine to be appropriate, pursuant to R.S. 37:1285.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 37:1270, 37:1285.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:336 (January 2011).

##### Subchapter B. Unprofessional Conduct

#### §7603. Unprofessional Conduct

A. In the exercise of its duties the board has determined to define the term *unprofessional conduct*, as set forth in R.S. 37:1285(A)(13), as conduct that includes but is not limited to the departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice or the ethics of the medical profession including, but not limited to, the principles established by the American Medical Association, the American Osteopathic Association, and relevant medical specialty associations, or the commission of any act contrary to honesty, justice, good morals, patient safety or the best interest of the patient, whether committed in the course of the physician's practice or otherwise, and whether committed within or without of this state. For illustrative purposes only, *unprofessional conduct* includes but is not limited to:

1. *Sexual Misconduct*—any act of sexual intimacy, contact, exposure, gratification, abuse, exploitation or other sexual behavior with or in the presence of a patient or any other individual related to the physician's practice of medicine regardless of consent. Such conduct may be verbal, physical, visual, written or electronic, or it may consist of expressions of thoughts, feelings or gestures that are sexual

or reasonably may be construed by a patient or other individual as sexual or which may reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient or another individual. Sexual misconduct between a physician and a former patient after termination of the physician-patient relationship may also constitute *unprofessional conduct* if the sexual misconduct is a result of the exploitation of trust, knowledge, influence or emotions derived from the professional relationship;

2. *Disruptive Behavior*—aberrant behavior, including but not limited to harassment, sexual or otherwise, manifested through personal interaction with physicians, employees, co-workers, hospital personnel, health care professionals, patients, family members or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care or jeopardizing patient safety;

3. *Failing to Cooperate with the Board*—physicians shall cooperate with and assist the board to carry out its duties. A physician shall, among other matters:

a. respond or provide information or items requested, respond to a subpoena, or complete an evaluation within the time designated by the board or its staff;

b. not attempt to influence the board, its members, staff or agents by means of intimidation, falsehoods or other means prohibited by law;

c. not contact members of the board directly or through others in an attempt to influence the outcome of an investigation or disciplinary proceeding; and

d. not contact or attempt to contact a complainant or witness regarding a complaint or an investigation by the board for purposes of intimidation or harassment;

4. *Failing to Maintain Independent Medical Judgment*—at all times while engaged in the practice of medicine in this state a physician shall exercise independent medical judgment in the sole interest of the patient. To that end a physician shall not:

a. allow a non-physician to impose or substitute his, her, or its judgment for that of the physician in the exercise of the rights and privileges provided for by medical licensure; or

b. enter into or attempt to enforce an agreement that would have the effect of requiring a physician to abandon a patient, deny a patient continuity of care, or interfere with the patient's freedom of choice in the selection of health care providers or services;

5. *Improperly Delegating or Supervising*—physicians retain responsibility to their patients for the training, delivery and results of medical services rendered to their patients. A physician shall not:

a. delegate professional responsibilities to a person the physician knows or has reason to know is not qualified by training, experience or licensure to perform them; or

b. fail to exercise appropriate supervision over a person who is authorized to practice only under physician supervision;

6. *Exercising Undue Influence*—physicians shall exercise their professional judgment in the best interest of their patients. A physician shall not:

a. place his or her own financial gain over the interest and welfare of a patient in providing, furnishing, prescribing, recommending or referring a patient for therapy,

treatment, diagnostic testing or other health care items or services;

b. perform, or refer a patient to another to perform, unnecessary tests, examinations or services which have no legitimate medical purpose; or

c. exercise influence over a patient in such a manner as to exploit the patient or his or her third party payor for financial gain of the physician or of a third party through the promotion or sale of services, goods, appliances or drugs;

7. *Enabling the Unauthorized Practice of Medicine*—A physician shall insure that he or she is practicing in conformity with the law and in a lawful setting. A physician shall not:

a. enter into any arrangement, as medical director or otherwise, that allows or condones an unlicensed individual to engage in the practice of medicine, as defined by R.S. 37:1261(1), in the absence of the physician's direction and immediate personal supervision—i.e., where the physician is physically present on the premises at all times that the unlicensed individual is on duty and retains full responsibility to patients for the training, delivery and results of all services rendered; or

b. practice in a pain management clinic that is not licensed by the Department of Health and Hospitals pursuant to R.S. 40:2198.11 et seq., or in any other clinic or medical setting that the physician knows or reasonably should know, is operating in violation of the law or the board's rules;

8. *Practicing or Enabling Practice by Impaired Provider*—a physician shall not:

a. engage in the practice of medicine while under the influence of a mood-altering substance that compromises or has the potential to compromise a physician's medical judgment or practice, irrespective of whether or not prescribed by another physician or authorized practitioner; or

b. prescribe any mood-altering substance to a patient, who is a physician or another licensed health care provider, without instructing the patient to refrain from practice while under the influence of the substance. The physician's record on the patient shall document this instruction;

9. *Failing to Adhere to Accepted Practices*—Physicians shall practice within the scope of their education, training and experience;

10. *Failing to Create or Maintain Medical Records*—a physician shall create and maintain adequate and legible patient records. In addition, a physician shall:

a. not falsely create or alter a medical record or destroy a medical record except as authorized by law;

b. upon receipt of proper authorization, and in conformity with R.S. 40:12999.96, make patient medical records in the physician's possession available within a reasonable period of time to the patient, the patient's representative, or another physician or licensed health care provider;

c. make arrangements for patient access to medical records of the physician after relocating or closing a medical practice, retiring, or being prohibited from practice by consent, decision or other order of the board;

d. make arrangements, or assist another physician practicing in the same group make arrangements, for access

by a physician or patients to their medical records after the physician has left a medical practice, relocated a practice to a new location, closed a practice, or retired;

e. insure proper destruction of medical records by methods approved by state or federal authorities; and

f. not abandon or desert medical records.

B. By implementing the meanings set forth hereinabove, the board does not intend to restrict and indeed reserves unto itself its authority and right to take action based upon R.S. 37:1285(A)(13), in any instance in which the particular facts and circumstances of a complaint, investigation or adjudication rise to a level of conduct that it may, in its discretion, determine constitutes unprofessional conduct.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 37:1270, 37:1285.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:336 (January 2011).

### **§7605. Effect of Violation**

A. Any violation or failure to comply with the provisions of this Subchapter shall be deemed unprofessional conduct and conduct in contravention of the board's rules, in violation of R.S. 37:1285(A)(13) and (30), respectively, as well as violation of any other applicable provision of R.S. 37:1285(A), providing cause for the board to suspend, revoke, refuse to issue or impose probationary or other restrictions on any license held or applied for by a physician culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1261-1292, 37:1270, 37:1285.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:337 (January 2011).

Robert L. Marier, M.D.  
Executive Director

1101#094

## **RULE**

### **Department of Health and Hospitals Board of Medical Examiners**

Licensure and Certification; Reciprocity  
(LAC 46:XLV.311 and 353)

The Louisiana State Board of Medical Examiners, pursuant to the authority of the Louisiana Medical Practice Act, R.S. 37:1261-1292, and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., has amended §311 and §353 of its rules governing Licensure and Certification of Physicians. The amended rules are set forth below.

#### **Title 46**

### **PROFESSIONAL AND OCCUPATIONAL STANDARDS**

#### **Part XLV. Medical Professions**

#### **Subpart 2. Licensure and Certification**

#### **Chapter 3. Physicians**

#### **Subchapter B. Graduates of American and Canadian Medical School and Colleges**

#### **§311. Qualifications for License**

A. To be eligible for a license, an applicant shall:

1. - 5.h....

6. have completed at least one year of postgraduate clinical training in a medical internship or equivalent program accredited by the American Council on Graduate Medical Education (ACGME) of the American Medical Association, or by the American Osteopathic Association (AOA), or by the Royal College of Physicians and Surgeons (RCPS) of Canada, and approved by the board. A combined postgraduate year one training program that is not accredited shall be deemed to satisfy the requirements of this Section provided each program comprising the combined program is accredited by the ACGME or by the AOA or by the RCPS.

B. Pursuant to Paragraph A.5 of this Section applicants are required to have successfully completed all steps, components, parts, or levels of an approved examination within the prior 10 years and within a span of not more than 10 years. An applicant who is otherwise fully qualified for licensure, but whose successful completion of all steps, components, parts, or levels of an approved examination spanned a period of more than 10 years, shall nonetheless be eligible for licensing provided that such applicant:

1. has within the past three years, completed a medical residency training program accredited by the ACGME, AOA, or RCPS; and

2. is continuing training in a postgraduate year four or fellowship program in the same specialty or subspecialty; or

3. has been practicing or is commencing practice in the same specialty or subspecialty in which the physician completed residency or fellowship training.

C. The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1271, 37:1272, 37:1274 and 37:1275.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 10:908 (November 1984), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:513 (June 1990), LR 27:836 (June 2001), LR 31:1583 (July 2005), LR 37:337 (January 2011).

#### **Subchapter E. Licensure by Reciprocity**

#### **§353. Qualifications for Medical Licensure by Reciprocity**

A. An applicant who possesses and meets all of the qualifications and requirements specified by §§311-313 of this Chapter, including but not limited to the restrictions and limitations prescribed by §387, save for successfully passing the examinations in the manner specified by §311.A.5.a-h within the prior 10 years, shall nonetheless be eligible for licensing if such applicant possesses, as of the time the application is filed and at the time the board passes upon such application, a current, unrestricted license to practice medicine issued by the medical (whether allopathic or osteopathic) licensing authority of another state, and the applicant has, within 10 years prior to the date of application, taken and successfully passed a written certification or recertification examination administered by and leading to certification or recertification by a specialty board recognized by the American Board of Medical

Specialties (ABMS) or the American Osteopathic Association (AOA).

B. ...

C. The waiver of qualifications provided by §311.B of this Chapter shall be available to reciprocity applicants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and 37:1276.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 10:910 (November 1984), amended LR 14:149 (March 1988), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 16:516 (June 1990), LR 27:839 (June 2001), LR 31:1583 (July 2005), LR 37:338 (January 2011).

Robert L. Marier, M.D.  
Executive Director

1101#093

### **RULE**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

CommunityCARE Program  
Primary Care Provider Referral Exemptions  
(LAC 50:1.2911)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:1.2911 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

#### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

##### **Part I. Administration**

##### **Subpart 3. Medicaid Coordinated Care**

##### **Chapter 29. CommunityCARE**

##### **§2911. PCP Referral/Authorization**

A. The following Medicaid covered services do not require written referral/authorization by the recipient's PCP:

1. - 18. ...

19. services provided through the Office of Public Health's Women, Infants, and Children (WIC) program;

20. services provided by school based health centers to recipients age 10 and older;

21. dentures for adults; and

22. services provided by urgent care facilities and retail convenience clinics.

a. These providers furnish walk-in, non-routine care as an alternative to emergency department care when access to primary care services is not readily available to meet the health needs of the recipient.

b. Urgent care facilities and retail convenience clinics must provide medical record notes of the visit to the recipient's PCP within 48 hours of the visit.

B. - B.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:909 (June 2003), amended LR 32:405 (March 2006), amended by the Department of Health and

Bruce D. Greenstein  
Secretary

1101#085

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

Estate Recovery (LAC 50:I.8101-8105)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:I.8101-8105 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part I. Administration**

**Subpart 9. Recovery**

**Chapter 81. Estate Recovery**

**§8101. Definitions**

*Authorized Representative*—the executor or succession attorney if a succession has been opened. If there is no executor or succession attorney, an heir, family member or the decedent’s last authorized representative listed on the decedent’s most recent Medicaid application.

\* \* \*

*Estate*—the gross (total value) estate of the deceased as determined by Louisiana succession law and any interest in any property, whether movable or immovable, corporeal or incorporeal.

\* \* \*

*Homestead*—consists of a residence occupied by the owner and the land on which the residence is located, including any building and appurtenances located thereon, and any contiguous tracts up to a total of five acres if the residence is within a municipality, or up to a total of 200 acres of land if the residence is not located in a municipality. This same homestead shall be the individual’s home which was occupied by the recipient immediately prior to the recipient’s admission to a long term care facility or when the recipient began receiving home and community-based services.

*Individual’s Home*—the primary place of residence of the deceased recipient which was occupied by the recipient immediately prior to the recipient’s admission to a long term care facility or when the recipient began receiving home and community-based services.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:801 (April 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:339 (January 2011).

**§8103. General Provisions**

A. Medicaid estate recovery is not a condition of eligibility. The applicant/recipient shall be informed at the time of application/redetermination that federal law and regulations mandate estate recovery action by the states and that medical assistance claims paid by the department may be subject to estate recovery. A notice of estate recovery is provided to the applicant as part of the application process.

**B. Recovery Limits**

1. Recovery can only be made after the death of the recipient’s surviving spouse, if any, and only at the time when the recipient has no surviving child under age 21, or a child who is blind or disabled as defined in Section 1614 of the Social Security Act. Recovery may be deferred until the death of the surviving spouse or children reach the age of 21 or are no longer blind or disabled.

2. Recovery cannot be made for Medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the Medicaid State Plan.

**C. Recovery Adjustments**

1. ...

2. Recovery shall be waived if it will cause an undue hardship on any child of the deceased recipient.

3. The recovery may be lessened by reducing the estate value in consideration of reasonable and necessary documented expenses incurred by the decedent’s heirs to maintain the homestead during the period in which the recipient was in a long term care facility or received home and community-based services, if the homestead is part of the estate.

**D. Recovery Notice**

1. The department will seek recovery for medical assistance from the decedent’s estate. The family or heirs will be given advance notice of the proposed action and the time frame in which they have the opportunity to apply for an undue hardship waiver and/or dispute the recovery.

2. A notice of Medicaid estate recovery will be served on the executor, authorized representative or succession attorney of the decedent’s estate. If there is no executor, authorized representative or succession attorney, the notice will be sent to the family or the heirs. The notice shall specify the following information:

a. the deceased recipient’s name and Medicaid identification number;

b. - c. ...

d. the dates of services associated with the recovery action and the estimated amount of the department’s claim, i.e., amount to be recovered against the recipient’s estate;

e. ...

f. the authorized representative’s right to a hearing;

g. the method by which the authorized representative may obtain a hearing; and

h. ...

3. The notice shall request that copies of all succession pleadings filed in connection with the succession of the decedent, including any judgment(s) of possession be provided to the department.

a. In the event no succession has been judicially opened, the department is to be advised as to when such

documents will be available and/or when the succession is expected to be opened.

E. Recovery Privilege

1. The claim of the department shall have a privilege on the total estate with a priority equivalent to an expense of last illness as prescribed in Civil Code Article 3252 et seq.

2. The department may file a proof of claim based on its privilege.

F. Recovery Exclusions

1. If an individual was insured under a qualifying long-term care insurance partnership policy and received Medicaid benefits as a result of resources being disregarded in the eligibility determination, the department shall not seek adjustment or recovery from the individual's estate for the amount of the resources disregarded.

a. The resource disregard is determined on a 1:1 ratio. For each \$1 of a qualifying long-term care insurance partnership policy benefit, \$1 of countable resources is disregarded or excluded during the eligibility determination process.

2. The department shall not seek recovery or adjustment from an individual's estate for the amount of Medicare cost-sharing benefits paid on behalf of an individual that was enrolled in any one of the following Medicaid programs:

a. Qualified Medicare Beneficiaries (QMB);

i. including individuals who are classified as QMB Plus and receive full Medicaid coverage in addition to QMB benefits;

b. Specified Low-Income Beneficiaries (SLMB);

i. including individuals who are classified as SLMB Plus and receive full Medicaid coverage in addition to SLMB benefits;

c. Qualified Disabled and Working Individuals (QDWI); or

d. Qualified Individuals (QI).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:801 (April 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1891 (September 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:339 (January 2011).

**§8105. Administrative Review**

A. Informal Review and Administrative Appeal of Agency Decision. Through the informal review and administrative process, any authorized representative may request that the agency review and reconsider any or all aspects of a particular recovery matter in which he/she is involved.

1. If the authorized representative disagrees with the estimated amount and/or the basis for the estate recovery and is requesting an undue hardship waiver, the authorized representative must submit the following information to the department within 30 days of receipt of the estate recovery notice:

a. a written request for an informal review which states the basis for the disagreement(s) along with all of the supporting documentation to substantiate the disagreement; or

b. a completed notarized hardship waiver application along with all of the documentation needed to support the request for a hardship waiver.

2. If the authorized representative wishes to obtain a copy of the claims history upon which the recovery amount is based, the HIPPA authorization form enclosed with the recovery notice must be completed and returned to the department within five days of receipt of the recovery notice.

3. The written request for an informal review and/or hardship waiver must be post marked or delivered to the department on or before the 30th day from receipt of the estate recovery notice.

4. If the written request for an informal review and/or the completed notarized hardship waiver application along with all supporting documentation is not received within the 30 day period, the action set out in the estate recovery notice shall be the final agency decision.

5. If the written request for an informal review and/or the completed notarized hardship waiver application along with all supporting documentation is received timely, the department shall conduct an informal review of the estate recovery decision.

a. The informal review may be conducted in-person, via phone or other electronic media and/or through a review of the documentation.

b. Following the informal review, the department will issue a written notice to the authorized representative of the reason(s) for its findings and the amount owed by the estate.

B. The authorized representative shall have 30 days from the date of mailing of the estate recovery notice to seek an administrative appeal with the appropriate state administrative tribunal.

C. In addition to the provisions of this Section, any aggrieved party shall have the administrative appeal rights available pursuant to the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:802 (April 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:340 (January 2011).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Bruce D. Greenstein  
Secretary

1101#086

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

Medical Necessity Criteria (LAC 50:I.1101)

Editor's Note: This Rule is being repromulgated to correct a typographical error. The original Rule may be viewed in its entirety on pages 2563-2564 of the November 20, 2010 edition of the *Louisiana Register*.

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:I.Chapter 11 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part I. Administration**

**Subpart 1. General Provisions**

**Chapter 11. Medical Necessity**

**§1101. Definition and Criteria**

A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

B. In order to be considered medically necessary, services must be:

1. deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

2. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

D. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

1. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2563 (November 2010), repromulgated LR 37:341 (January 2011).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and

Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Bruce D. Greenstein  
Secretary

1101#087

**RULE**

**Department of Health and Hospitals  
Bureau of Health Services Financing  
and  
Office of Aging and Adult Services**

Nursing Facilities—Standards for Payment  
Level of Care Determinations  
(LAC 50:II.10154 and 10156)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services has amended LAC 50:II.10154 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part II. Medical Assistance Program**

**Subpart 3. Standards for Payment**

**Chapter 101. Standards for Payment for Nursing  
Facilities**

**Subchapter G. Levels of Care**

**§10154. Nursing Facility Level of Care Determinations**

A. The purpose of the level of care (LOC) determination is to assure that individuals meet the functional and medical necessity requirements for admission to and continued stay in a nursing facility. In addition, the LOC determination process assists persons with long-term or chronic health care needs in making informed decisions and selecting options that meet their needs and reflect their preferences.

B. In order for an individual to meet nursing facility level of care, functional and medical eligibility must be met as set forth and determined by the Office of Aging and Adult Services (OAAS). The functional and medical eligibility process is frequently referred to as the "nursing facility level of care determination."

1. - 3. Repealed.

C. OAAS shall utilize prescribed screening and assessment tools to gather evaluation data for the purpose of determining whether an individual has met the nursing facility level of care requirements as set forth in this Subchapter.

1. - 2. Repealed.

D. Individuals who are approved by OAAS, or its designee, as having met nursing facility level of care must continue to meet medical and functional eligibility criteria on an ongoing basis.

E. A LOC screening conducted via telephone shall be superseded by a face-to-face Minimum Data Set (MDS) assessment, Minimum Data Set for Home Care (MDS-HC) assessment, or Audit Review LOC determination as determined by OAAS or its designee.

F. If on an audit review or other subsequent face-to-face LOC assessment, the LOC findings are determined to be incorrect, the audit or subsequent face-to-face LOC assessment findings will prevail.

G. The department may require applicants to submit documentation necessary to support the nursing facility level of care determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:2083 (November 2006), amended by the Office of Aging and Adult Services, LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:341 (January 2011).

### §10156. Level of Care Pathways

A. Several potential avenues of functional and medical eligibility shall be investigated by OAAS. These avenues are called pathways. The pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations. In order to meet the nursing facility level of care, an individual must meet eligibility requirements in only one pathway.

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an individual has met or triggered a level of care pathway.

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual's:

1. functional capabilities;
2. receipt of assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL);
3. current medical treatments and conditions; and
4. other aspects of an individual's life.

#### D. Activities of Daily Living Pathway

1. The intent of this pathway is to determine the individual's self-care performance in activities of daily living during a specified look-back period (e.g., the last seven days, last three days, etc. from the date the LOC assessment was completed). Consideration will be given to what the individual actually did for himself or herself and/or how much help was required by family members or others.

2. The ADL Pathway identifies those individuals with a significant loss of independent function measured by the amount of assistance received from another person in the period just prior to the day the LOC assessment was completed.

3. The ADLs for which the LOC assessment elicits information are:

- a. locomotion—moving around in the individual's home;
- b. dressing—how the individual dresses/undresses;
- c. eating—how food is consumed (does not include meal preparation);
- d. bed mobility—moving around while in bed;

e. transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);

f. toileting—includes getting on and off the toilet, wiping, arranging clothing, etc;

g. personal hygiene (excludes baths/showers); and

h. bathing (excludes washing of hair and back).

4. Since an individual can vary in ADL performance from day to day, OAAS trained assessors shall capture the total picture of ADL performance over the specified look-back period.

5. In order for an individual to be approved under the ADL Pathway, the individual must score at the:

a. limited assistance level or greater on toilet use, transferring, or bed mobility; or

b. extensive assistance level or greater on eating.

#### E. Cognitive Performance Pathway.

1. This pathway identifies individuals with the following cognitive difficulties:

a. short term memory which determines the individual's functional capacity to remember recent events;

b. cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:

i. planning how to spend his/her day;

ii. choosing what to wear; or

iii. reliably using canes/walkers or other assistive devices/equipment, if needed;

c. making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

2. In order for an individual to be approved under the Cognitive Performance Pathway, the individual must:

a. be severely impaired in daily decision making, never or rarely makes decisions;

b. have a memory problem and daily decision making is moderately impaired. The individual's decisions are consistently poor or unsafe. Cues or supervision is required at all times;

c. have a memory problem and daily decision making is severely impaired, never or rarely makes decisions;

d. have a memory problem and is sometimes understood. The individual's ability is limited to making concrete requests;

e. have a memory problem and is rarely or never understood;

f. be moderately impaired in daily decision making.

The individual's decisions are consistently poor or unsafe. Cues or supervision is required at all times and the individual is usually understood. The individual has difficulty finding words or finishing thoughts and prompting may be required;

g. be moderately impaired in daily decision making.

The individual's decisions are consistently poor or unsafe. Cues or supervision is required at all times. The individual is sometimes understood and his/her ability is limited to making concrete requests;

h. be moderately impaired in daily decision making. The individual's decisions are consistently poor or unsafe. Cues or supervision is required at all times and the individual is rarely or never understood;

i. be severely impaired in daily decision making, never or rarely makes decisions. The individual has difficulty finding words or finishing thoughts and prompting may be required;

j. be severely impaired in daily decision making, never or rarely makes decisions. The individual is sometimes understood and his/her ability is limited to making concrete requests;

k. be severely impaired in daily decision making, never or rarely makes decisions, and the individual is rarely or never understood;

l. be minimally impaired in daily decision making. The individual has some difficulty in new situations or his/her decisions are poor. Cues and supervision is required in specific situations only and the individual is sometimes understood. The individual's ability is limited to making concrete requests; or

m. be minimally impaired in daily decision making. The individual has some difficulty in new situations or his/her decisions are poor. Cues and supervision is required in specific situations only and the individual is rarely or never understood.

#### F. Physician Involvement Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

2. Physician visits and physician orders will be investigated for this pathway. Consideration will be given to the physician visits in the last 14 days, excluding emergency room exams, and physician orders in the last 14 days, excluding order renewals without change or hospital inpatient visits.

3. In order for an individual to be approved under the Physician Involvement Pathway, the individual must have:

a. one day of doctor visits and at least four new order changes within the last 14 days;

b. at least two days of doctor visits and at least two new order changes within the last 14 days; or

c. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:

i. a copy of the physician's orders;

ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or

iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

4. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

#### G. Treatments and Conditions Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself. The following treatments and conditions shall be investigated for this pathway:

a. stage 3-4 pressure sores in the last 14 days;

b. intravenous feedings in the last 7 days;

c. intravenous medications in the last 14 days;

d. daily tracheostomy care and ventilator/respiratory suctioning in the last 14 days;

e. pneumonia in the last 14 days and the individual's associated IADL or ADL needs or restorative nursing care needs;

f. daily respiratory therapy provided by a qualified profession in the last 14 days;

g. daily insulin injections with two or more order changes in the last 14 days:

i. supporting documentation shall be required for the daily insulin usage and the required order changes; and

h. peritoneal or hemodialysis in the last 14 days.

2. In order for an individual to be approved under the Treatments and Conditions Pathway, the individual must have:

a. any one of the conditions listed in §15104.G.4.a; and

b. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:

i. a copy of the physician's orders;

ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or

iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

3. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

#### H. Skilled Rehabilitation Therapies Pathway

1. The intent of this pathway is to identify individuals who have received, or are scheduled to receive, at least 45 minutes of physical therapy, occupational therapy, or speech therapy in the last seven days or within seven days from the date the LOC assessment is completed.

2. In order for an individual to be approved under the Skilled Rehabilitation Therapies Pathway, the individual must have:

a. received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the last seven days;

b. at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled for the next seven days; or

c. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:

i. a copy of the physician's orders for the scheduled therapy;

ii. the home health care plan notes indicating the therapy received during the required look-back period;

iii. progress notes indicating the physical, occupational, and/or speech therapy received or scheduled;

iv. nursing facility or hospital discharge plans indicating the therapy received for the required look-back period or therapy scheduled for the required look-forward period; or

v. the appropriate form designated by OAAS to document the individual's medical status and condition.

#### I. Behavior Pathway

1. The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the

community during the seven day look-back period. The behavior challenges may include:

- a. wandering;
- b. verbally or physically abusive behavior;
- c. socially inappropriate behavior; and
- d. delusions or hallucinations.

2. In order for an individual to be approved under the Behavior Pathway, the individual must have:

a. exhibited any one of the following behaviors four to six days of the look-back period, but less than daily:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or
- v. resisted care;

b. exhibited any one of the following behaviors daily:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or
- v. resisted care; or

c. experienced delusions or hallucinations within the required look-back period that impacted his/her ability to live independently in the community.

J. Service Dependency Pathway

1. The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the Adult Day Health Care Waiver, the Elderly and Disabled Adult Waiver or receiving long-term personal care services.

2. In order for individuals to be approved under this pathway, the afore-mentioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status.

3. There must have been no break in services during this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011).

Bruce D. Greenstein  
Secretary

1101#088

**RULE**

**Department of Health and Hospitals  
Licensed Professional Counselors Board of Examiners**

Professional Assistance Program  
(LAC 46:LX.Chapter 23)

In accordance with R.S. 49:950 et seq., of the Louisiana Administrative Procedure Act, as well as R.S. 37:1110 and 37:1120, the Licensed Professional Counselors Board of Examiners has amended its existing rules and regulations by adding LAC 46:LX.Chapter 23, relative to the Mental Health Counselor, Licensed Marriage and Family Therapist,

and Intern Professional Assistance Program. These revisions are necessary to implement this program.

Specifically, the Licensed Professional Counselors Board of Examiners has adopted new Sections 2301-2315, relative to this program.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part LX. Licensed Professional Counselors Board of  
Examiners**

**Subpart 2. Professional Standards for Licensed  
Marriage and Family Therapists**

**Chapter 23. Mental Health Counselor, Licensed  
Marriage and Family Therapists and  
Intern Professional Assistance Program**

**§2301. Authority**

A. The Louisiana Licensed Professional Counselors Board of Examiners recognizes that impairments in the functioning of persons interning, licensed, certified or registered to practice as licensed professional counselors, or licensed marriage and family therapists can affect the competent delivery of mental health counseling and marriage and family therapy, and impair professional judgment.

B. Therefore, in order to safeguard the public health, safety, and welfare of the people of this state, as mandated by R.S. 37:1102 et seq., the Licensed Professional Counselors Board of Examiners establishes the Professional Assistance Program. Authority for such program is contained at R.S. 37:1110 and 37:1120. This program is sometimes referred to hereafter as the "Professional Assistance Program", or "PAP".

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37:1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:344 (January 2011).

**§2303. Purpose and Scope; Immunity**

A. The goal of the Professional Assistance Program is to provide for public protection through monitoring and a remedial course of action applicable to licensed professional counselors and licensed marriage and family therapists and interns who are functionally impaired in their ability to safely practice. Impairments include, but are not limited to mental, physical, and addictive disorders or other conditions. The program also supports recovery through preventative measures and allows entrance into the program before harm occurs.

B. A licensed professional counselor or licensed marriage and family therapist or intern may enter the program subsequent to voluntary disclosure of impairment via an initial or renewal application for a credential. When evidence of impairment arises as a possible causative or contributing factor in disciplinary proceedings, the board may offer this program to the subject of those proceedings. If the subject agrees to enter the program, disciplinary proceedings may be suspended pending program completion. If the subject refuses to enter the program, the disciplinary process shall continue. Participation in the program can be voluntary, but may also be required as a prerequisite to continued mental health counseling practice

in accordance with the conditions of any consent order, compliance or adjudication hearing. A licensed professional counselor, licensed marriage and family therapist or intern who enters the program may be allowed to maintain his/her credential while in compliance with the requirements of their program, subject to the board's discretion.

C. Professionals who participate in evaluation, monitoring or treatment and who are approved or designated by the board to render these services, as well as Professional Assistance Program committee members and board members, who participate in Professional Assistance Program activities, will be provided immunity. The participating licensed professional counselor or licensed marriage and family therapist or intern will be responsible for executing all required releases of information and authorizations required for the board or its designees to obtain information from any monitor, treatment or service provider concerning the licensed professional counselor or licensed marriage, family therapist or intern's progress and participation in the program, the Professional Assistance Program participant must agree in writing, to grant full immunity to, and hold harmless from any suit or claim, all Professional Assistance Program committee members, board members and those professionals who assist in their evaluation, monitoring, or treatment. This grant of immunity shall extend to all actions by such board members, Professional Assistance Program committee members, or participating professionals acting in good faith in the discharge of their duties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:344 (January 2011).

### **§2305. Program Implementation**

A. The program shall be administered by the board's Professional Assistance Committee, subject to overall supervision and control by the board. The board may utilize its discretionary authority to require or exclude specific components of this program for participants based on determination of the nature and severity of the impairment. Participation in the Professional Assistance Program may consist of all or part of the following components.

1. The program participant may be required to submit to an assessment relative to the impairment.

a. This assessment will be completed by a licensed mental health professional who is pre-approved by the board.

b. The format and content of this assessment will meet the requirements designated by the board, but will at a minimum contain information concerning:

i. previous inpatient/outpatient treatment episodes;

ii. relapse history;

iii. an assessment of the participant's psychosocial, physical, psychiatric, and other needs, relative to the impairment, and recommendations for future treatment.

c. The participant shall contact the designated mental health professional within 48 hours to schedule an evaluation, which should be scheduled within 72 hours. To the extent practicable, the assessment will then be forwarded to the board by the professional completing the assessment,

no later than 72 hours following the completion of the assessment.

2. The participant may be required to submit to ongoing monitoring for a period of up to five years. The beginning date of the monitoring period will be the date upon which a consent order is formally signed by the licensed professional counselor, licensed marriage and family therapist or intern and the board, or the date of the board's official decision to require program participation in the event of an adjudication hearing.

3. During the monitoring period the licensed professional counselor or licensed marriage and family therapist or intern may be required to submit to random drug and/or alcohol screenings as determined appropriate by the board, or other monitoring requirements which are pertinent and relative to the documented impairment.

a. The interval and timing of the required screening will be directed by a monitor who is pre-approved by the board. This monitor will be considered to have been duly selected by the board as its agent for the purposes of directing the required screens.

b. The results and reports of the results of all screens will be submitted to the board before the final business day of the month following the date of the screen.

4. Receipt by the board of any positive, unexplained substance abuse/drug screen or reports of non-compliance or complications relative to the impairment during the monitoring period may result in suspension, revocation, or other appropriate action pertaining to the licensed professional counselor, licensed marriage and family therapist or intern's credentials as determined appropriate by the board.

5. When the impairment is substance-related, the licensed professional counselor or licensed marriage family therapist or intern may be required to attend Twelve Step meetings on a regular basis as determined appropriate by the designated licensed substance abuse professional, and as approved or required by the board, but no less than four times monthly.

a. A pre-approved monthly log must be submitted to and received by the board at least five days after the final business day of the month following completion of the required meetings. It is the licensed professional counselor or licensed marriage and family therapist' or intern's responsibility to ensure that these logs are properly completed and received by the board by the designated date.

b. The log requires documentation of the name of the meeting chairman, and meeting dates and times.

c. Submission of logs will be required for at least one year of program participation, but may be required for any period of time up to and including the entire term of monitoring as determined by the designated licensed substance abuse professional and as approved or required by the board.

6. During the monitoring period for the licensed professional counselor, or licensed marriage and family therapist or intern may be required to participate in professional supervision with a board-approved and designated licensed professional counselor supervisor or licensed marriage and family therapist supervisor at a frequency determined by the board for a period of time up to and including the entire five year period of monitoring.

7. The board, in addition to other conditions, may require that the licensed professional counselor, licensed marriage and family therapist or intern obtain regularly scheduled therapy, at a prescribed interval.

a. The type and interval of therapy may be recommended by the designated pre-approved licensed professional responsible for program monitoring, as approved by the board.

b. The type and interval of therapy may be also required by the board independently.

c. The licensed professional counselor or licensed marriage and family therapist or intern may choose the licensed substance abuse professional or other qualified professional to provide this therapy, subject to board approval.

8. Other requirements for participation in the program may include, but are not limited to, limitations in the scope of the participant's mental health counseling or licensed marriage and family therapy practice, suspension of practice, or voluntary withdrawal from practice for a specific time.

9. In the event that a licensed professional counselor or licensed marriage and family therapist or intern relocates to another jurisdiction, the licensed professional counselor or licensed marriage and family therapist or intern will within five days of relocating be required to either enroll in the other jurisdiction's Professional Assistance Program and have the reports required under the agreement sent to the Louisiana Professional Counselor's Board of Examiners or if the other jurisdiction has no impairment professional program, the licensed professional counselor, or licensed marriage and family therapist or intern will notify the licensing board of that jurisdiction that the licensed professional counselor or licensed marriage and family therapist or intern is impaired and enrolled in the Professional Assistance Program. Should the licensed professional counselor, or licensed marriage and family therapist or intern fail to adhere to this requirement, in addition to being deemed in violation of the program requirements and corresponding consent order or adjudication, the licensed professional counselor, or licensed marriage and family therapist's or intern's credentials will be suspended or revoked.

10. The participating licensed professional counselor, licensed marriage and family therapist or intern shall notify the board office by telephone within 48 hours and in writing within five working days of any changes of the licensed professional counselor or licensed marriage and family therapist or intern's home or work address, telephone number, employment status, employer and/or change in scope or nature practice. The licensed professional counselor or licensed marriage and family therapist or Intern may satisfy the notice requirement by telephone, leaving a voice message on the board's office voicemail at times when the office is closed. A written confirmation from the PAP participant of the phone message is expected within five working days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:345 (January 2011).

### **§2307. Violations**

A. Notification of a violation of the terms or conditions of this agreement, consent order or adjudication order may result in the immediate suspension of the individual's licensed professional counselor or licensed marriage and family therapist or intern's credential to practice in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:346 (January 2011).

### **§2309. Costs and Fees**

A. The licensed professional counselor or licensed marriage and family therapist or intern shall be responsible for all fees and costs incurred in complying with the terms of this agreement, including but not limited to therapy, assessments, supervision, drug/alcohol screens, and reproduction of treatment or other records. By agreeing to participate in the Professional Assistance Program, the participant agrees to be solely responsible for all such costs or expenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:346 (January 2011).

### **§2311. Acceptance of Terms; Program Agreement**

A. The licensed professional counselor, licensed marriage and family therapist or intern must submit to the board an notarized agreement indicating acceptance of the required conditions of participation in the Professional Assistance Program as mandated by the board, along with all initial (or updated) releases or authorizations for the board or its designees to obtain information concerning the participant's participation and progress in the program. Such agreement shall also delineate requirements for release from the program, including but not limited to certification of completion by treatment providers, written evidence of full compliance with the program agreement, and two written reports attesting to the participant's current mental status to be submitted by mental health professionals approved by the board. The program agreement shall also state that the board may monitor the participant for up to two years following program completion. This agreement and the required release and authorizations must be submitted prior to the issuance of any initial credential or re-issuance of a renewal of a credential.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:346 (January 2011).

### **§2313. Confidentiality**

A. The board will, to the full extent permissible, under R.S. 44:4 et seq., maintain an agreement or consent order relating to the licensed professional counselor or licensed marriage family therapist or intern's participation in the Professional Assistance Program as a confidential matter. The board retains the discretion to share information it deems necessary with those persons providing evaluation/assessment, therapy, treatment, supervision,

monitoring or drug/alcohol testing or reports. Violation of any terms, conditions, or requirements contained in any consent order, or board decision can result in a loss of the participant's license credentials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:346 (January 2011).

### **§2315. Recusal**

A. Any board members or Professional Assistance Program committee members who participate in any manner in any particular Professional Assistance Program case shall recuse themselves from voting in any subsequent application or disciplinary matter involving the licensed professional counselor, licensed marriage and family therapist, or intern who is the subject of such Professional Assistance Program case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1110 and 37: 1120.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 37:347 (January 2011).

Gloria Bockrath  
Board Chair

1101#061

## **RULE**

### **Department of Transportation and Development**

#### **Access Connection Permits and Driveway Permits (LAC 70:I.Chapter 15 and II.531)**

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950, et seq., the Department of Transportation and Development hereby enacts Part I, Chapter 15, of Title 70 entitled "Access Connection Permits", and amend Part II, Chapter 5, §531 of Title 70 entitled "Driveway Permits," in accordance with the provisions of R.S. 48:344.

### **Title 70 TRANSPORTATION**

#### **Part I. Highway Construction**

#### **Chapter 15. Access Connection Permits**

##### **§1501. Introduction**

A. The Louisiana Department of Transportation and Development (DOTD) recognizes that landowners have certain rights of access. The DOTD also recognizes that access connections are a major contributor to traffic congestion, increase the degradation of transportation facility operations, can result in decreased highway capacity, cause driver and pedestrian confusion, and can increase safety hazards.

B. Most roadside interference can be attributed directly to vehicular traffic entering, exiting, and parking adjacent to accesses for residential developments, business establishments, and commercial roadside developments.

C. Incumbent with this is the obligation to protect the investment of the state in the highway system. Access connections granted by the DOTD can be restrictive.

D. The Louisiana Department of Transportation and Development (DOTD) has the authority to require permits

for access connections as set forth in R.S. 48:344. Access connection permits are required in order to achieve the following:

1. to ensure safe and orderly movement for vehicular traffic entering and leaving the highway;
2. to prevent hazardous and indiscriminate parking on, along, or adjacent to the roadway surface;
3. to preserve adequate sight distances at intersections (including streets and driveways);
4. to encourage beautification of property frontage;
5. to ensure uniform design and construction of access on highway right-of-way.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:347 (January 2011).

### **§1503. Definitions**

*Access Connection Permits*—shall be defined and required as follows:

1. single-family residential access connections:
  - a. single family residential—1 to 5 homes on a single access connection (Six or more residences on a single shared access or a single property subdivided for multiple homes must apply as a multi-family residential access.);
  - b. residential sporting and recreation camps (Full-time or part-time residential camps used for hunting, fishing, etc.);
2. non-commercial agricultural operations:
  - a. unimproved land (farm, pasture, or wooded; passenger vehicle or farm equipment access and use only);
3. traffic generator access connections:
  - a. place of business (e.g., retail outlets, banks, restaurants, etc.);
  - b. medical facilities (e.g., doctors' offices, hospitals, urgent care facilities, assisted living homes, etc.);
  - c. religious facilities (e.g., churches, synagogues, etc.);
  - d. multi-family residential developments (e.g., subdivisions, condominiums, apartment complexes, trailer parks, etc.);
  - e. educational facilities (e.g., schools, colleges, daycares, after-school daycares, etc.);
  - f. lodging facilities (e.g., hotels, vacation rentals, motels, RV parks, etc.);
  - g. recreational facilities (e.g., sports fields, public swimming pool, parks, golf courses, bowling alleys, theme parks, etc.);
  - h. private clubs (e.g. country clubs, golf clubs, yacht clubs, etc.);
  - i. emergency services (e.g., fire station, ems stations, police stations, etc.);
  - j. mixed-use developments (any combination of above-listed uses);
  - k. public facilities (libraries, court houses, city halls, jails, conference/convention centers, etc.);
  - l. commercial agricultural operations (processing and/or wholesale operations; cotton gin, rice mill, sugar mill, etc.);
  - m. oil, natural gas, logging, and other natural resource harvesting operations;
  - n. utility company access;
  - o. any other connections that do not fit a category listed above;

4. temporary permits:
  - a. short-term oil, natural gas, logging, or other natural resource harvesting operations;
  - b. short-term haul road;
  - c. short-term construction access to a building site until an access connection is approved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:347 (January 2011).

**§1505. Public Road/Street Connections**

A. Public road or street connections shall follow the normal project development process and shall only be requested by the local authority within the jurisdiction over the roadway.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:348 (January 2011).

**§1507. Facilities Requiring Access Connection**

A. Facilities requiring access connection permits may be either new facilities or existing facilities which are remodeled, undergo a change of use, or any other change(s) to the operations of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37: 348 (January 2011).

**§1509. Personal Injury/Property Damage**

A. The applicant agrees to hold harmless the DOTD and its duly appointed agents and employees against any action for personal injury or property damage sustained by reason of the exercise of a permit, whether or not the same may have been caused by the negligence of the DOTD, its agents, or its employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37: 348 (January 2011).

**§1511 Requirements**

A. The location, design, and construction of the access shall be in accordance with the rules and regulations stated in the Section of this Chapter entitled Access Connection Requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37: 348 (January 2011).

**§1513. Process for Acquiring an Access Permit**

A. The access connection permit application process shall be initiated by the applicant during the preliminary planning and development stages of a project. Applicant shall coordinate the initial requests with the Louisiana DOTD district permit specialist where the subject property is located.

B. The process for acquiring an access connection permit shall be defined in DOTD policies.

C. If required by DOTD Policy, a traffic impact study (TIS) and/or a traffic signal study (TSS) shall be completed by the applicant and approved by the DOTD district traffic operations engineer (DTOE). These studies shall be completed in accordance with DOTD policies.

D. At the direction of the DOTD district office, a request for an access connection permit may require the submission

of any required supporting documentation to the DOTD district office. Actual work on an access connection shall not begin until the application has been approved by the DOTD. Required permit application supporting documentation may include some or all of the following:

1. detailed property location, including but not limited to:
  - a. location address;
  - b. legal property description (with professional land surveyor stamp);
  - c. property frontage dimensions;
  - d. relative locations of all access connections, intersecting streets, signals, railways, and crossovers within a specified distance from the property lines. This distance shall be specified by the DOTD district engineering administrator (DA) and/or DTOE;
  - e. information on any nearby or adjacent properties owned and/or controlled by the applicant(s), including anticipated future land use(s);
  - f. posted speed limit of adjacent roadways;
2. right-of-way information, including but not limited to:
  - a. measured rights-of-way for the subject property;
  - b. easements (utility, drainage, etc.) and locations of same;
  - c. known existing access restrictions;
  - d. property lines;
  - e. right-of-way widths for all adjacent roadways (state, parish, local, private, etc.);
3. proposed site plan drawing, fully dimensioned to-scale on 11" x 17" or 24" x 36" paper, showing all, but not limited to, the following:
  - a. existing roadway alignment for all adjacent roadways;
  - b. requested access connection location;
  - c. distance from requested access connection to nearest property line(s) and nearest intersecting roadways (in all directions along the roadway from the subject property);
  - d. distance from right-of-way to all buildings, structures, gas pumps, etc. on the proposed site;
  - e. plan for internal parking, drives, traffic flow patterns, traffic control devices, markings, truck/service vehicle routing, emergency access, etc. Autoturn or similar analysis must be shown for adequate design vehicle(s);
  - f. detailed geometry of proposed access connection (width, radii, lane use, etc.)—must conform to DOTD standard plans. Autoturn or similar analysis must be shown for adequate design vehicle(s);
  - g. detailed pavement design of proposed access connection (base type and thickness, pavement thickness, curb treatment, etc.);
  - h. sidewalk and ADA ramps, where required;
  - i. proposed treatment of right-of-way area between and adjacent to proposed and existing access connection(s);
  - j. sight distance triangles for proposed access connection;
4. if a traffic impact study is required, the review and approval process shall be as outlined in DOTD policies. Copies of approvals shall be attached to the access connection permit;
5. copies of a traffic signal study, and/or traffic signal permit application, if applicable, shall be included. These

studies shall be completed within the guidelines of DOTD policies;

6. temporary traffic control plan for work within the right-of-way—see Section entitled Construction Requirements;

7. railroad crossing permit—see Section entitled Railroad Crossings;

8. copies of permits obtained for access and building rights from local authorities;

9. permanent signing and pavement marking plans which conform to DOTD standards and the most current edition of the manual on Uniform Traffic Control Devices;

10. detailed plans of required or proposed mitigation (turn lanes, etc.);

11. additional information, drawings, or documents as required by the district engineer administrator or his/her designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37: 348 (January 2011).

#### **§1515. Permit Conditions**

A. The applicant must be the owner of the property or his/her legally designated representative.

B. Any access connection or approach constructed under this permit shall be for the bona fide purpose of securing access to the subject property.

C. The entire highway right-of-way affected by this work shall be restored to at least the same condition that existed prior to the beginning of the work.

D. The applicant may be required to post a bond in order to secure an access connection permit. This bond shall be required and posted in accordance with DOTD policy, and shall be an amount as identified by the DOTD district office as sufficient to cover the expenses of all work or improvements required within the DOTD right-of-way as a condition of an access connection permit. The cost of restoration shall be borne by the applicant.

E. All access connections, approaches, or other improvements on the right-of-way shall comply with DOTD standards and be subject to the approval of the district engineer administrator or his/her designee.

F. All access connections in the DOTD right-of-way shall at all times be subject to inspection by the DOTD.

G. Post-construction inspections are mandatory for traffic generator access connections.

H. After having been constructed, access connection(s) shall at all times be subject to inspection with the right reserved to require changes, additions, repairs, and relocations at any time considered necessary to permit the location and/or to provide proper and safe protection to life and property on or adjacent to the highway. The cost of making such mandated changes, additions, repairs, and relocations shall be borne by the applicant.

I. The relocations or alterations of any access, approach, or other improvement constructed on the right-of-way shall require a new permit.

J. If the applicant is unable to commence construction within 12 months of the permit issue date, the applicant may request a six month extension from the DOTD. No more than two six-month extensions may be granted under any circumstances. If the access connection is not constructed within 24 months from the permit issue date, the permit shall

be considered expired. Any person wishing to reestablish an access connection permit that has expired shall begin again with the application procedures.

K. When the adjacent highway is under construction, a letter of no objection must be obtained from the highway contractor before the application can be approved and the permit can be issued. A copy of this letter shall be attached to the permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:349 (January 2011).

#### **§1517. Application Requirements**

A. The applicant shall submit a design that conforms with all requirements included herein. Design(s) shall also conform with all DOTD standards, where applicable.

B. The applicant shall make any and all changes or additions necessary to make the proposed access satisfactory to the DOTD.

C. Three copies of the completed application package, including all supplemental documentation, are required with each application. One copy is to be retained by the district office, and two copies are to be forwarded to DOTD Headquarters Permits Section. The application package shall include all supporting documentation as required by the district engineer administrator or his/her designee and as described in the Section entitled Process for Acquiring an Access Permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:349 (January 2011).

#### **§1519. Permit Reapplication and Modifications to Existing Commercial Access Connections**

A. The provisions of this Section do not apply to single-family residential access connection permits, as described in the definitions Section of this Chapter.

B. If the property is reconstructed/remodeled/redeveloped, the owner shall submit a new application for an access connection permit. The new application shall contain all information and documentation as described in Section entitled Process for Acquiring an Access Permit, as well as a copy of the old access connection permit.

C. If the property owner reconstructs the access connection, a new access connection permit application shall be submitted. The DOTD reserves the right to make changes to the original permit during this process.

D. If DOTD road maintenance and/or construction operations affect the condition or necessitate the reconstruction, improvement, modification, or removal of an existing access connection, a re-evaluation of the access connection geometrics, location, etc. shall be performed by the district traffic operations engineer. The access connection permit shall be re-issued according to the most current DOTD standards, and DOTD reconstruction efforts shall follow these standards. The cost to reconstruct the access connection to the right-of-way shall be borne by the DOTD. Any additional costs to improve on-site conditions shall be borne by the property owner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:349 (January 2011).

## §1521. Access Connection Requirements

### A. Location of Access Connections

1. The frontage of any parcel of property adjacent to a public highway shall be considered to be confined within lines drawn from the intersection of the property lines with the right-of-way lines of the highway to the roadway surface, and perpendicular to the axis of the highway; or if the axis is a curve, to the center of curvature; or a combination of the two. Those lines shall be known as boundaries.

2. In addition, the following constraints shall apply.

a. Full access shall not be granted within the functional influence area of the intersection. For purposes of this Chapter, the functional influence area of an intersection shall be defined as the area beyond the physical intersection of two roadways and/or access connection points that:

i. comprises decision and maneuvering distances;

ii. comprises any required vehicle storage lengths, either determined by length of existing storage lanes, observed queue lengths, or anticipated post-development queue lengths, all as determined by the district traffic operations engineer;

iii. includes the length of road upstream from an oncoming intersection needed by motorists to perceive the intersection and begin maneuvers to negotiate it.

3. Access connections located near or within storage limits of existing or proposed right- or left-turn lanes with no alternate locations shall be located as far as possible from the intersection and may be granted right-in/right-out only access connection conditions.

4. If the subject property is located at the intersection of two routes, an access connection may be permitted on one of the routes. The determination of the access connection location shall be at the discretion of the DOTD according to this rule and other applicable DOTD policies.

5. The applicant shall provide sufficient on-site circulation to ensure the safe ingress and egress of vehicles on the site. This on-site circulation shall be contained within the owned property boundaries and shall not encroach upon the right-of-way in any way. Adequate on-site vehicle storage shall be provided in order to prevent any overflow of queued/waiting traffic in the travel lane(s) of the adjacent roadway(s).

6. Access connections shall be designed and constructed so that a driver can maneuver entering, parking, and exiting without backing onto the adjacent roadway.

B. The granting of access shall adhere to the following decision hierarchy.

1. Each property or group of adjacent properties with a single owner or development plan shall be granted no more than one access point, unless Paragraphs 4 and 5 of this Section are completed and approved. The DOTD reserves the right to limit access to adjacent properties to those access connections which already exist. All properties shall receive adequate access, but that may be accomplished through required access sharing with a neighboring property.

2. The owner shall be required to gain access through the appropriate governmental local authorities for access on a non-state route.

3. The DOTD may require adjacent properties to share access through a single access point. If shared access is required by the DOTD, a copy of the shared access

agreement shall be submitted to the DOTD as part of the driveway permit and shall be signed by all involved property owners. If an applicant does not meet the minimum requirements for a single access connection, and the adjacent properties do not have existing access connections, the DOTD may issue an access connection permit with the condition that the permitted access connection shall be placed along the property line with the stipulation that upon development of the adjacent property, the permitted access connection shall be shared and any reconstruction or reconfiguration required at the future time shall be the responsibility of the permittee(s).

4. A request for an access connection on a state route where alternative access connection opportunities exist on non-state route(s) shall be accompanied by a traffic impact study. This study shall comply with the guidelines and policies set forth by the DOTD for such studies. In order to consider state route access in these cases, the study shall show that the lack of access on the state route causes unreasonable negative impacts to the traffic flow in the vicinity of the property.

5. Requests for access connections in excess of one access connection or for an access connection on a state route where non-state route access exists must be reviewed and approved by the district engineer administrator. Such requests shall be accompanied by a traffic impact study. This study shall comply with the guidelines and policies set forth by the DOTD for such studies. In order to consider an additional access connection or an access connection on a state route where non-state route access exists, the study shall show that the lack of the requested access connections causes unreasonable negative impacts to the traffic flow in the vicinity of the property and shall demonstrate that an additional access connection will contribute to the overall improvement of the safety and efficiency of the adjacent roadways and of the transportation system.

C. The construction of parking within the limits of the state right-of-way is specifically prohibited. Facilities which require parking shall provide such within the limitations of the facility and shall not encroach upon the right-of-way.

D. Access connections which extend or travel parallel to the roadway shall not be permitted. This includes access near gasoline pumps or other structures requiring vehicular access. Any such pumps or structures shall be located a minimum distance of 15 feet from the right-of-way line in order that all on-site access lanes shall be located outside of the right-of-way.

E. Gates, fences, signage, landscaping, or other decorative or access-control features (i.e. gated subdivision) shall not be located within the right-of-way. Any such access-control feature shall be located so that a minimum storage of two vehicles (50' storage length minimum) is provided outside of the limits of the right-of-way. Gated access shall not be permitted as an approach to a traffic signal.

F. Display of merchandise for sale within the limits of right-of-way (including, but not limited to, automobiles, farm equipment, agricultural produce, fireworks, tents, etc.) or the storage of farm implements within the limits of right-of-way is strictly prohibited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:350 (January 2011).

### **§1523. Limited Access Highways**

A. On those highways which have been designated as limited access highways, or along which service roads have been constructed, access shall be permitted to connect only to the service roads and not to the main traveled highways.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:351 (January 2011).

### **§1525. Access Connections—Spacing and Sharing**

A. Every effort shall be made by the district traffic operations engineer and/or district engineer administrator to designate approved locations of access connections within existing property limits so that the spacing between adjacent access connections is maximized.

B. A minimum spacing as defined in DOTD policy shall be maintained between access connections. If frontage is not available to maintain minimum spacing of access connections, the DOTD reserves the right to require adjacent property owners to share a single access connection.

C. When necessary to maintain the corridor and preserve mobility, adjacent property owners may be required by the DOTD to share an access connection (new or existing). This provision applies to both residential and commercial applicants. Under this provision, a residential applicant shall only be required to share use with other residential applicants. A commercial applicant shall only be required to share an access connection with other commercial applicants.

D. The DOTD may require adjacent commercial applicants to share access connections and/or provide connectivity between properties and parking lots in an effort to limit the number of access connections along the right-of-way.

E. When access connection sharing and/or property connectivity is required by the DOTD of independent property owners, it shall be the responsibility of the property owners to develop maintenance and cost agreements. The signed agreement shall be submitted to the DOTD as part of this application.

F. Any costs resulting from the requirement to share access connections or provide property connectivity shall be borne by the involved property owners and shall not be the responsibility of the DOTD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:351 (January 2011).

### **§1527. Access Connection Operational Restrictions**

A. DOTD reserves the right to restrict operations at an access connection.

B. Such restrictions may include, but are not limited to:

1. turn restrictions (e.g., right-in/right-out only);
2. truck only or no trucks;
3. entrance-only or exit-only.

C. Restricted movements cannot be limited to certain times of day or days of week.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:351 (January 2011).

### **§1529. Access Connections on Roadways with Medians**

A. On roadways with center medians of any type, access connections will not be permitted to align with median cuts or crossovers, and shall be located as far from these cuts and crossovers as possible within property limit constraints.

B. DOTD reserves the right to require the applicant to modify, relocate, or construct crossovers to facilitate the movement of additional traffic expected to be generated by the proposed facility.

C. All access on roadways with medians may be restricted to right-in/right-out movements only, and shall be constructed in such a way as to prevent any other movements. This shall apply to both residential and commercial access.

D. Median opening spacing, locations, and operations with regard to access connections shall be as defined in DOTD policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:351 (January 2011).

### **§1531. Design Requirements**

A. There are multiple standard plans for access connection types. The DOTD district engineer administrator or his/her designee will aid in determining the appropriate type for each application at the initial access connection permit meeting. These standard access connection types must be applied in their entirety without modification, unless otherwise recommended or approved by the district traffic operations engineer. The permissible design of access connection returns shall be governed by the type of access connection to be constructed and shall be as shown in the appropriate detail of the standard plans for access connections.

B. All single-family residential and traffic generator access connections shall be constructed with permanent hard surface type materials (i.e. asphalt or concrete) as shown on the standard plans for access connections. Aggregate access connections shall not be permitted within the right-of-way for these types of connections. The hard surface type materials shall extend the following distances from the edge of pavement:

1. single-family residential access connections: 10 feet from the edge of pavement;
2. traffic generator access connections: 25 feet from the edge of pavement.

C. Non-commercial agricultural operations may not be required to be constructed of hard surface type materials.

D. All entrances and exits shall be located so that drivers approaching or using them will have adequate sight distance in all directions along the highway in order to maneuver safely and without interfering with traffic. Minimum required sight distance shall be calculated using the methods outlined in the AASHTO Geometric Design Guide for sight distance based on the posted speeds of the adjacent roadway or a speed other than the posted speed limit for these calculations.

E. All access connections shall be designed and constructed in accordance with all DOTD plans and specifications regarding drainage requirements. Culvert sizes, proposed elevations and proposed slopes shall be approved by the DOTD prior to issuance of an access

connection permit. The DOTD may require a drainage study to be performed at the expense of the applicant.

F. Access connections shall be constructed according to DOTD Standard Plans and other applicable policies and provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:351 (January 2011).

### **§1533. Construction Requirements**

A. During construction in the right-of-way, appropriate temporary traffic control devices shall be used to maintain traffic on the roadway in a safe manner. All temporary traffic control devices and the placement of same shall conform to the most current DOTD standards.

B. All public notices shall be handled by the DOTD district office personnel. Closure plans and times shall be submitted to the district traffic operations engineer for review according to the following:

1. 5 working days before construction if traffic control plan has been approved or is contained in the plans that were approved;

2. 10 working days before construction if traffic control plan must be submitted for lane closures not addressed in the plans.

C. The allowable times, days, and duration of lane closures shall be as determined by the district traffic operations engineer. All lane closures should be scheduled in a way that minimizes the impact to roadway traffic.

D. Nighttime closures may be required.

E. The services of an independent DOTD-approved inspector shall be obtained to inspect the construction of all DOTD-required improvements in the DOTD right-of-way. The inspection process shall be in accordance with current DOTD policy. The DOTD district office may elect to perform independent inspections of work. Satisfactory completion and acceptance of the improvements by DOTD will be based upon the reports received from the inspector(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:352 (January 2011).

### **§1535. Improvements to the Adjacent Transportation System**

A. The DOTD may require mitigation on the adjacent roadway network and facilities due to the effects of the proposed development and access connection location(s). Expense for such requirements shall be borne by the applicant.

B. Mitigation, which may be required by the DOTD, may be determined through a complete traffic impact study and/or traffic signal study review process. Required mitigation shall be reviewed by the district engineer administrator. Any required mitigation shall be noted on the permit, and bond amounts shall be appropriate for such mitigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:352 (January 2011).

### **§1537. Coordination with Local Authorities**

A. Additional permits may be required by other local governing authorities.

B. It is the responsibility of the applicant to determine the need for additional permits from local authorities, and to obtain these permits.

C. Access connection permits shall not be granted based on the possession of other required state or local permit(s). The issuance of a DOTD access connection permit does not guarantee the issuance of other required state or local permit(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:352 (January 2011).

### **§1539. Temporary Access Connection Permits**

A. Temporary access connection permits may be granted for a period of time as specified on the permit. This time period shall be specified on the permit prior to issuance.

B. Temporary access connection permits shall not be issued for a period of time to exceed one year.

C. A temporary access connection permit may be extended or reissued as approved by the district engineer administrator.

D. Applications for temporary access connection permits shall be accompanied by a bond per DOTD policies.

E. All temporary access connections installed under a temporary access connection permit shall be constructed using non-permanent materials (i.e. aggregate). Concrete or asphalt should not be used for temporary access connections.

F. The property owner shall be responsible for removal of any materials tracked onto the roadway by property operations on a daily and continual basis until such time that the temporary access connection is removed.

G. Temporary access connection permits may be issued where access from a state highway is needed on a short-term basis. Such instances may include, but are not limited to:

1. access during construction for a site where the future permanent access will be located on another roadway not within the state highway right-of-way;

2. use of an existing access connection during the permit application process for a change in land use.

H. Temporary access connection permits to controlled access facilities shall not be allowed under any circumstances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:352 (January 2011).

### **§1541. Appeals Process**

A. Any decision rendered by the DOTD district office may be appealed by the applicant to the DOTD headquarters staff.

B. Appeals shall be filed in accordance with the DOTD appeals policies set forth in LAC 70:I.1101 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:352 (January 2011).

#### **§1543. Utility Company Access Connections**

A. Permits requested by utility companies for access connections within the DOTD right-of-way shall be limited to 15 feet in width.

B. Permit requests for access wider than 15 feet will require proof of necessity before approval. Such requests shall be approved by the district traffic operations engineer.

C. Prior to permit approval, a DOTD permit for placement of a cable closure box or maintenance cabinet on DOTD right-of-way must have been granted.

D. The following special condition must be noted on utility company permits when the applicant does not have control of the frontage (abutting) property:

“This permit is issued subject to permittee obtaining prior approval for any access(s) and producing written permission from abutting property owner(s). Otherwise, said access(s) shall be completely removed from the highway right-of-way. Access(s) is(are) to be used for the maintenance of utilities only and is(are) not to be used for any other purposes.”

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:353 (January 2011).

#### **§1545. Bus Stop Shelters**

A. Permits for bus stop shelters within the highway right-of-way shall only be granted to public bodies (e.g. municipality, police jury, etc.).

B. Applications for such permits must include the following information:

1. name of the agency requesting the permit;
2. type and size of shelter or bench, including diagram of such (to scale with dimensions);
3. exact proposed location with respect to the highway and to the right-of-way limits;
4. drainage requirements;
5. access requirements;
6. signed statement that approaches will be maintained by the agency in an acceptable state of repair.

C. Such structures shall not be permitted when they do not comply with these regulations or when they are proposed at a location that will interfere with needed highway operations or maintenance (e.g., sight distance, shoulders, drainage, etc.).

D. The DOTD is to maintain full control and regulatory authority over any such structure and may require removal at any time.

E. If a bus stop shelter or bench is no longer in use or service, it shall be removed at the expense of the public body to which the permit for such was granted. The roadway shall be returned to a condition which matches the adjacent area, including replacement of regular curb and gutter, pavement, shoulders, etc. as directed by the DOTD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:353 (January 2011).

#### **§1547. Railroad Crossings**

A. Railroad tracks crossing highways shall conform to the permit supplement titled Rules and Regulations

Governing the Construction of Railroad Grade Crossings on State Highways.

B. It is the responsibility of the applicant to contact the appropriate railroad agency, submit any required documentation, and pay any required fees in order to obtain a permit from the railroad agency.

C. DOTD shall not issue an access connection permit until the appropriate railroad permit(s) has (have) been secured by the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:353 (January 2011).

#### **§1549. Failure to Comply**

A. Unlawful access connections shall be:

1. any driveway, street, or other connection which violates the provisions of this Chapter;
2. any driveway, street, or other connection which violates the provisions of the permit issued; or
3. any driveway, street, or other connection which is constructed without an access connection permit.

B. The DOTD shall give 30 days notice by certified mail to the owner of such connection to remove same if it is a prohibited connection or cause it to conform to regulations if it is not an authorized connection.

C. At the time of owner notification, the DOTD shall place barricades across the unlawful access connection. The barricades shall be marked with an approved sticker as “ILLEGAL.”

D. If the owner is unknown or cannot be found, a written notice shall be affixed to the barricade stating that the access connection is unlawful and shall be removed within 30 days from the date specified on the sticker.

E. Failure to remove within the specified period serves as forfeiture of all rights thereto and the department shall remove the unlawful access connection. The owner and/or any other person responsible therefore remains liable for any damage to public property or expenditure of highway funds resulting from the installation or removal of the unlawful access connection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 37:353 (January 2011).

### **Part II. Utilities**

#### **Chapter 5. Standards Manual for Accommodating Facilities on Highway Right-of-Way**

##### **§531. Driveway Permits**

A. Guidelines. Driveway permits are required in order to assure safe and orderly movement for vehicular traffic entering and leaving the highway; to abolish hazardous and indiscriminate parking adjacent to the roadway surface; to preserve adequate sight distances at intersections; to encourage beautification of property frontage and to insure uniform design and construction of driveways on highway right-of-way. The DOTD’s authority to require permits for driveways is set forth in R.S. 48:344. All rules governing the installation of driveways are now located at LAC 70:I.Chapter 15, Access Connection Permits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:381-382, 48:193 and 48:344.

HISTORICAL NOTE: Promulgated by the Department of Transportation and Development, LR 20:317 (March 1994), amended LR 37:353 (January 2011).

Sherri H. Lebas, P.E.  
Secretary

1101#036

## RULE

### Department of Transportation and Development Transportation Research Center

#### LTRC Transportation Training and Education Fund (LAC 70:XXVII.Chapter 1)

In accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Transportation and Development hereby enacts Part XXVII, Chapter 1, of Title 70 entitled "LTRC Transportation Training and Education Fund", in accordance with the provisions of R.S. 48:105.1.

#### Title 70

#### TRANSPORTATION

#### Part XXVII. Louisiana Transportation Research Center (LTRC)

#### Chapter 1. LTRC Transportation Training and Education Fund

#### §101. General Provisions

A. All fees collected shall be deposited in the fund or disbursed from the fund as provided in R.S. 48:105.1 and in the following rules.

B. All monies deposited in the fund in compliance with the statute shall be used to defray the expenses associated with workforce development activities of the Louisiana Transportation Research Center (LTRC) and LTRC's Transportation and Training Education Center (TTEC).

C. Allowable expenses include (but are not limited to):

1. course development and delivery costs for courses organized and managed by LTRC;
2. direct workforce development training costs, such as reimbursement for events or courses organized and managed by LTRC;
3. maintenance and upkeep of the TTEC building not funded by Louisiana State University;
4. maintenance, upkeep, upgrade, or replacement of the audio visual equipment, to include all software and hardware used by LTRC for workforce development activities, such as classes, conferences, meetings, etc.;
5. purchase, maintenance, upkeep, upgrade, or replacement of computer equipment, including peripherals, used in the development and dissemination of training materials used for workforce development;
6. supplies and other items purchased in direct support of workforce development activities.

D. Prohibited expenses include:

1. purchase of supplies not directly related to workforce development activities;
2. any and all travel expenses;
3. individual membership dues to professional organizations;
4. conference/meeting/training registration fees;

5. any form of personal use, such as cash advances, gifts, entertainment-related expenses;

6. alcohol.

E. Authorized Account Agents

1. Signatory authority for the fund will be the same as that authority granted for department individuals to sign contracts.

2. The chief engineer of the department will have authority to disburse funds in single transaction amounts not to exceed \$50,000.

3. The Director of LTRC will have authority to disburse funds in single transaction amounts not to exceed \$20,000.

4. The Associate Director of Training for LTRC will have authority to disburse funds in single transaction amounts not to exceed \$2,000.

F. Fund Accounting

1. Standard accounting procedures will be administered by the LTRC Business Office.

2. The LTRC Business Office duties will include preparation of monthly reconciliation reports to be approved by the LTRC Associate Director of Training.

3. The LTRC Business Office will serve as technical advisor for accounting matters associated with this fund.

G. Ethics

1. Agents authorized to collect and disburse funds from the account must comply with the regulations relative to ethical conduct under the Code of Governmental Ethics, Chapter 15 of Title 42 of the Louisiana Revised Statutes.

AUTHORITY NOTE: Promulgated by the Louisiana Department of Transportation and Development, Louisiana Transportation Research Center, pursuant to R.S. 48:105.1.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Transportation and Development, Louisiana Transportation Research Center, LR 37:354 (January 2011).

#### §103. Calculation of Fees

A. Governmental attendees shall be charged the actual cost of the program attended.

B. Non-governmental attendees shall be charged the actual cost of the program plus a 66 percent surcharge (approximate).

AUTHORITY NOTE: Promulgated by Louisiana Department of Transportation and Development, Louisiana Transportation Research Center, pursuant to R.S. 48:105.1.

HISTORICAL NOTE: Promulgated by Louisiana Department of Transportation and Development, Louisiana Transportation Research Center, LR 37:354 (January 2011).

Sherri H. Lebas, P.E.  
Secretary

1101#040

## RULE

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

#### Spotted Seatrout Management Measures (LAC 76:VII.341)

The Wildlife and Fisheries Commission does hereby amend a rule, LAC 76:VII.341, modifying the existing rule. Authority for adoption of this Rule is included in R.S. 56:6(25)(a) and 56:326.3.

**Title 76**

**WILDLIFE AND FISHERIES**

**Part VII. Fish and Other Aquatic Life**

**Chapter 3. Saltwater Sport and Commercial Fishery**

**§341. Spotted Seatrout Management Measures**

**A. Commercial Season; Quota; Permits**

1. The commercial season for spotted seatrout whether taken from within or without Louisiana state waters shall remain closed until January 2 of each year, when it shall open and remain open until the maximum annual quota is reached, or on the date projected by the staff of the Department of Wildlife and Fisheries that the quota will be reached, whichever comes first. The commercial harvest or taking of spotted seatrout is prohibited during the period from sunset on Friday through sunrise on Monday, and there shall be no possession of spotted seatrout in excess of the recreational limit during the period between 10 p.m. and 5 a.m.

2. - 3.d. ...

4. The commercial taking or commercial harvesting of spotted seatrout shall be prohibited within Louisiana waters west of the Mermentau River.

**B. - C. ...**

AUTHORITY NOTE: Promulgated in accordance with Act Number 157 of the 1991 Regular Session of the Louisiana Legislature, R.S.56:6(25)(a); R.S. 56:306.5, R.S. 56:306.6, 56:325.1(A) and (B); R.S. 56:325.3; R.S. 56:326.3; Act 1316 of the 1995 Regular Legislative Session; and Act 1164 of the 2003 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 18:199 (February 1992), amended LR 22:238 (March 1996), LR 24:360 (February 1998), LR 26:2333 (October 2000), LR 30:1509 (July 2004), LR 30:2498 (November 2004), repromulgated LR 32:125 (January 2006), amended LR 32:1071 (June 2006), LR 37:355 (January 2011).

Robert J. Barham  
Secretary

1101#039

**RULE**

**Department of Wildlife and Fisheries  
Wildlife and Fisheries Commission**

**Use of Yo-yo's and Trotlines in Lake Lafourche  
(LAC 76:VII.116)**

The Wildlife and Fisheries Commission hereby adopts regulations on yo-yo's and trotlines in Lake Lafourche in Caldwell Parish, Louisiana.

**Title 76**

**WILDLIFE AND FISHERIES**

**Part VII. Fish and Other Aquatic Life**

**Chapter 1. Freshwater Sport and Commercial Fishing**

**§116. Lake Lafourche**

A. The Wildlife and Fisheries Commission hereby adopts the following regulations applicable to the use of yo-yo's and trigger devices when used in Lake Lafourche in Caldwell Parish.

1. No more than 50 yo-yos or trigger devices shall be allowed per person.

2. Except for those devices that are attached to a privately owned pier, boathouse, seawall, or dock, each yo-yo or trigger device shall be clearly tagged with the name, address, and telephone number of the owner or user.

3. When in use, each yo-yo or trigger device shall be checked at least once every 24 hours, and all fish and any other animal caught or hooked, shall be immediately removed from the device.

4. Except for those devices that are attached to a privately owned pier, boathouse, seawall, or dock, each yo-yo or trigger device must be re-baited at least once every 24 hours.

5. Except for those metal objects located above the water that are affixed to a private pier, dock, houseboat, or other manmade structure which is designed for fishing, no yo-yo or trigger device shall be attached to any metal object.

6. Except for a metal object used strictly in the construction of a pier, boathouse, seawall, or dock, no metal object which is driven into the lake bottom, a stump, tree, or the shoreline shall be used to anchor a yo-yo or trigger device.

7. Except for those devices that are attached to a privately owned pier, boathouse, seawall, or dock, when not being used in accordance with the provisions of this Paragraph, each yo-yo or trigger device shall be removed from the waterbody immediately.

B. The Wildlife and Fisheries Commission hereby adopts the following regulations applicable to the use of trotlines when used in Lake Lafourche in Caldwell Parish.

1. All trotlines shall be clearly tagged with the name, address, and phone number of the owner or user and the date of placement. The trotline shall be marked on each end with a floating object that is readily visible.

2. At any given time, no person shall set more than three trotlines with a maximum of 50 hooks each.

3. All trotlines shall have an eight foot cotton leader on each end of the trotline.

4. Except for those metal objects located above the water that are affixed to a private pier, dock, houseboat, or other manmade structure which is designed for fishing, no trotline shall be attached to any metallic object.

5. Each trotline shall be attended daily when in service.

6. When not in use, each trotline shall be removed from the waterbody by the owner or user.

C. A violation of any of the provisions of this Section shall be a class one violation, except there shall be no imprisonment. In addition, any device found in violation of this Section shall be immediately seized by and forfeited to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:326.3 and 56:6(32).

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 37:355 (January 2011).

Stephen J. Oats  
Chairman

1101#038

# Notices of Intent

## NOTICE OF INTENT

### Department of Agriculture and Forestry Office of Agriculture and Environmental Sciences Seed Commission

#### Laboratory Testing and Seed Sampling Fees (LAC 7:XIII.113)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., and with the enabling statute, R.S. 3:1433, the Department of Agriculture & Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, is intending on amending this regulation to increase fees for certain laboratory analysis currently offered by the department and to provide additional services. The department, through its seed lab, currently provides laboratory testing of seeds and seed mixtures to farmers, growers and individuals who request a lab analyses. These requests are voluntarily made by the farmer, grower or individual and the service is provided over and above the regulatory function of the department in regard to seed. The seed lab is the only lab, public or private, in the state that provide these services. The cost of the tests has continued to increase to the point that the cost of the tests exceeds the fees being charged. A survey of 23 other states determined that the department is charging 15 to 50 percent less than any of these other states. The proposed amendments adjust certain existing laboratory testing fees to help recover the actual cost of the tests. Additional lab testing fees and a fee for the taking of samples by departmental employees are being added to accommodate requests for these services by farmers, growers, and other persons requesting these services.

#### Title 7 AGRICULTURE AND ANIMALS Part XIII. Seeds

#### Chapter 1. Louisiana Seed Law Subchapter A. Enforcement of the Louisiana Seed Law

#### §113. License Fee; Laboratory and Sampling Fees

A. The annual fee for a seed dealer's license shall be \$100.

B. The following laboratory and sampling fees shall be applicable to all seed testing conducted by this department:

1. standard germination test only, purity test only or noxious weed examination only: \$10 each (except grasses and seed containing high inert: \$20 each);
2. complete test (purity and germination): \$17.50 each (except grasses and seed containing higher inert: \$30 each);
3. Accelerated Aging: \$15 each;
4. Texas Cool Test: \$20 each;
5. Tetrazolium: \$20 each;
6. examination of 4-pound rice seed sample for presence of red rice: \$10;
7. Varietal Purity: \$12;
8. Herbicide Bioassay: \$25;
9. seed mixtures:

- a. purity only: \$10 for first 2 components; \$5 for each additional component;
- b. germination only: \$10 for first 2 components; \$5 for each additional component;
- c. complete test (purity, germination, noxious weed exam): \$10 per component;
10. seed count per pound: \$5;
11. service sample taken by departmental inspector: \$15 per sample; and
12. priority sample: \$25.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Seed Commission, LR 4:105 (April 1978), amended LR 7:164 (April 1981), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 12:825 (December 1986), LR 14:603 (September 1988), LR 29:2632 (December 2003), LR 36:1220 (June 2010), LR 37:

#### Family Impact Statement

It is anticipated that the proposed action will have no significant effect on the (1) stability of the family, (2) authority and rights of parents regarding the education and supervision of their children, (3) functioning of the family, (4) family earnings and family budget, (5) behavior and personal responsibility of children, or (6) ability of the family or a local government to perform the function as contained in the proposed action.

#### Small Business Statement

It is anticipated that the proposed action will not have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed action to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

#### Public Comments

Interested persons may submit written comments, data, opinions, and arguments regarding the proposed action. Written submissions are to be directed to Lester Cannon, Department of Agriculture and Forestry, 5825 Florida Boulevard, Baton Rouge, LA 70806 and must be received no later than 4 p.m. on February 28, 2010. No preamble regarding these proposed regulations is available.

Mike Strain, DVM  
Commissioner

#### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Laboratory Testing and Seed Sampling Fees

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed action is not anticipated to have a direct material effect on governmental costs or savings. In addition to its regulatory activities, the Department's seed lab provides

laboratory seed testing to farmers, growers and individuals (consumers) who request a lab analysis. There is no other lab, public or private, in this state that performs this type of testing. The cost of the testing now exceeds the fees currently being charged. In order to help defray the costs associated with conducting such analyses, the proposed action increases fees for current tests, (germination test, purity test, complete test, accelerated aging, Texas cool test). It also provides for two additional tests, (herbicide bioassay, seed count), sets the fee for these new tests, and provides for a fee for samples taken by field inspectors at the request of the consumer.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed action is anticipated to increase revenues to the Seed Commission Fund by approximately \$2,110 annually, which is based upon a three-year average of service samples being tested by the lab for each test type. The proposed action does not impact the current seed inspection fee (regulatory fee) of \$0.20/100 pound, which is set by R.S. 3:1448.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Consumers requesting these testing services will be impacted by the proposed action in the aggregate amount of \$2,110 per year, based on a three year average of service samples. The specific test increases are: purity only - \$4.00, germination only - \$4.00, complete test - \$3.50, accelerated aging - \$3.00, Texas cool test - \$4.00. The new testing fees are as follows: herbicide bioassay - \$25.00, seed count - \$5.00. The inspector sample fee is \$15 normally or \$25 for a priority sample. The anticipated economic benefits of the proposed action is the continued premium price that sellers are able to charge for seeds whose purity, quality and germination rates have been verified by the lab and the savings in time and expense if these services were not available and the consumer has to go to an out-of-state lab for testing.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed action is not anticipated to have a direct material effect on competition or employment.

Craig Gannuch  
Assistant Commissioner  
1101#069

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Civil Service  
Board of Ethics**

Statements Filed Pursuant to Section 1111(E) of the Code of Governmental Ethics (LAC 52:I.1303)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Department of Civil Service, Louisiana Board of Ethics, has initiated rulemaking procedures to make amendments to the rules for the Board of Ethics to bring the rules into compliance with current statutory provisions (R.S. 42:1111 E.(2)(a)).

**Title 52  
ETHICS**

**Part I. Board of Ethics**

**Chapter 13. Records and Reports**

**§1303. Statements Filed Pursuant to Section 1111(E) of the Code of Governmental Ethics**

A. Statements filed pursuant to Section 1111(E) of the Code of Governmental Ethics shall:

1. be made under oath;
2. be filed with the board prior to or within 10 days after initial assistance is rendered; and
3. contain:
  - a. the name and address of the elected official;
  - b. the name and address of the person employing or retaining the official to perform the services;
  - c. a description of the nature of the work and the amount of the compensation for services rendered or to be rendered;
  - d. a brief description of the transaction in reference to which services are rendered or to be rendered; and
  - e. the date of initial assistance rendered.

B. The executive secretary shall maintain these statements suitably indexed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1134(A).

HISTORICAL NOTE: Promulgated by the Department of Civil Service, Board of Ethics, LR 23:1298 (October 1997), amended LR 37:

**Family Impact Statement**

The proposed rule changes have no impact on family formation, stability or autonomy, as described in R.S. 49.972.

**Public Comments**

Interested persons may direct their comments to Kathleen M. Allen, Louisiana Board of Ethics, P.O. Box 4368, Baton Rouge, LA 70821, telephone (225) 219-5600, until 4:45 p.m. on February 10, 2011.

Kathleen M. Allen  
Ethics Administrator

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Statements Filed Pursuant to Section 1111(E) of the Code of Governmental Ethics**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The estimated cost to implement the rule, regarding statements filed pursuant to R.S. 42:1111(E) is \$56 in FY 11, which accounts for the cost to publish the rule change in the *Louisiana Register*. Pursuant to R.S. 42:1111(E), no elected official of a governmental entity is allowed to receive anything of economic value for assisting a person in a transaction or in an appearance in connection with a transaction with the governmental entity or its official or agencies, unless he files a sworn written statement with the ethics board prior to or within ten days after initial assistance is rendered. Currently, filers are not required to include the date of initial assistance rendered. The proposed rule change provides for statements filed

pursuant to R.S. 42:1111(E) of the Code of Governmental Ethics to include the date of initial assistance rendered and be filed with the board within 10 days after initial assistance is rendered as currently required by statute (R.S. 42:1111 E (2)(a)).

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will have no anticipated effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will have no effect on the cost or economic benefits of affected persons.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will not have an effect on competition and employment.

Kristy Gary  
Deputy Ethics Administrator  
1101#067

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Student Financial Assistance Commission  
Office of Student Financial Assistance**

Scholarship/Grant Programs—Award Amount  
(LAC 28:IV.1401)

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its Scholarship/Grant rules (R.S. 17:3021-3025, 3041.10-3041.15, 3042.1, and 3048.1).

This rulemaking will amend Section 1405 of LASFAC's Scholarship/Grants rules for the Early Start Program to provide a different award amount for students enrolled at Louisiana Technical College campuses beginning with the spring semester of 2011.

**Title 28  
EDUCATION**

**Part IV. Student Financial Assistance—Higher  
Education Scholarship and Grant Programs**

**Chapter 14. Early Start Program**

**§1401. General Provisions**

A. - D. ...

E. Award Amount

1. The Early Start Program will pay postsecondary institutions, except for campuses of the Louisiana Technical College beginning with the spring semester of 2011, \$100 per college credit hour, not to exceed \$300 per course, for each course in which a student enrolled in a Louisiana public high school is eligible to enroll.

2. Beginning with the spring semester of 2011, the Early Start Program will pay \$50 per credit hour, not to exceed \$150 per course, for students enrolled at campuses of the Louisiana Technical College.

3. The award amount shall not be paid on behalf of students enrolled in nonpublic high schools or in home school; however, beginning with the 2008-2009 Academic Year (College), the program allows participating eligible Louisiana postsecondary institutions to enroll eligible eleventh and twelfth grade Louisiana nonpublic high school

and home school students at the same rate as the award amount that funding is provided for public high school students at these institutions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 33:2609 (December 2007), amended LR 34:240 (February 2008), LR 35:231 (February 2009), LR 37:

**Family Impact Statement**

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

**Small Business Statement**

The proposed Rule will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

**Public Comments**

Interested persons may submit written comments on the proposed changes (SG11127NI) until 4:30 p.m., February 10, 2008, to Melanie Amrhein, Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge  
General Counsel

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Scholarship/Grant Programs  
Award Amount**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rules will have no impact on state expenditures associated with the Early Start program in Fiscal Year 2011 because the program is capped by the amount appropriated by the Legislature. Executive Order BJ 10-20 resulted in a reduction of approximately \$540,000 in the Early Start program in Fiscal Year 2011. The proposed rule will change the distribution of the state appropriation for the Early Start Program to avoid denial of program services to participating students. To avoid denial of services to such students, the amount paid to Louisiana Technical College campuses would be reduced from \$100 to \$50 per credit hour with a limit of \$150 per semester. The amount paid to other Louisiana colleges and universities would remain at the current amount of \$100 per credit hour with a limit of \$300 per semester. However, the proposed rule will decrease state expenditures associated with the Early Start program in Fiscal Year 2012 and thereafter if the Legislature fully funds student demand for such services in future years.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state and local governments will not be affected by the proposed changes.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will allow continued participation by eligible students in the Early Start program. Executive Order BJ 10-20 reduced the Early Start budget by approximately \$540,000 for Fiscal Year 2011. This rule change merely reduces the amount paid to the Louisiana Technical College from \$100 per credit hour to \$50 per credit hour with a limit of \$150 per semester.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT  
(Summary)

These changes by itself will have no impact on competition or employment.

George Badge Eldredge  
General Counsel  
1101#024

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Student Financial Assistance Commission  
Office of Student Financial Assistance**

Scholarship/Grant Programs  
John R. Justice Grant Program  
(LAC 28:IV.Chapter 20)

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its Scholarship/Grant rules (R.S. 17:3021-3025, 3041.10-3041.15, 3042.1, 3048.1, 3048.5, and 3048.6).

This rulemaking will create a new Chapter 20 in the Commission's Scholarships/Grants rules to provide for the administration of the John R. Justice Student Grant Program by the Commission in accordance with a federal grant from the U.S. Department of Justice. The John R. Justice Student Grant Program will provide for student loan repayment beginning with the 2010-11 academic year for qualified prosecutors and public defenders in the state with the least ability to pay.

**Title 28  
EDUCATION**

**Part IV. Student Financial Assistance—Higher  
Education Scholarship and Grant Programs  
Chapter 20. John R. Justice Student Grant Program  
§2001. General Provisions**

A. The John R. Justice Student Grant Program (JRJ Grant) is administered by the Louisiana Student Financial Assistance Commission (LASFAC) in accordance with a federal grant from the United States Department of Justice.

B. Description, History and Purpose. The JRJ Grant is administered in accordance with the federal John R. Justice Prosecutors and Defenders Incentive Act, 42 U.S.C.A. 3797cc-21, to encourage qualified lawyers to choose careers as public defenders and prosecutors and to continue in that service.

C. Effective Date. The JRJ Grant will be administered by LASFAC beginning with the 2010-2011 federal fiscal year.

D. Award Amount. Each calendar year, twelve prosecutors will receive awards of \$5,000 each. Each calendar year, six public defenders will receive awards of \$10,000 each. One public defender and two prosecutors will be selected for participation from each of the First, Second, Third, and Fifth Louisiana Circuit Court of Appeal Districts. Two public defenders and four prosecutors will be selected for participation from the Fourth Louisiana Circuit Court of Appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

**§2003. Definitions**

A. Words and terms not otherwise defined in this Chapter shall have the meanings ascribed to such words and terms in this Section. Where the masculine is used in these rules, it includes the feminine, and vice versa; where the singular is used, it includes the plural, and vice versa.

*Adjusted Gross Income (AGI)*—gross income minus any deductions allowed under the federal income tax code (Title 26, United States Code).

*Eligible Loan*—an educational loan which is not paid in full and which was made under either the Federal Stafford Loan, Federal Graduate PLUS Loan, Federal Consolidation Loan, or Federal Perkins Loan program.

*Federal Fiscal Year*—October 1 to the following September 30.

*Full Time*—works at least 30 hours per week as a prosecutor or defense attorney.

*Least Ability to Pay*—have the lowest differential between AGI and one hundred fifty percent of the poverty level for a family of the lawyer's size among eligible applicants.

*Licensed*—holding a current license to practice law in the state of Louisiana.

*Poverty Level*—poverty guidelines as issued by the United States Department of Health and Human Services.

*Prosecutor*—a lawyer who is a full-time employee of the state or of a unit of local government (including tribal government) who prosecutes criminal or juvenile delinquency cases at the state or unit of local government level (including supervision, education, or training of other persons prosecuting such cases).

*Public Defender*—a lawyer who:

a. is a full-time employee of the state or with a unit of local government (including tribal government) who provides legal representation to indigent persons in criminal or juvenile delinquency cases including supervision, education, or training of other persons providing such representation; or

b. who is a full-time employee of a nonprofit organization operating under a contract with the state or with a unit of local government who devotes substantially all of the employee's full-time employment to providing legal representation to indigent persons in criminal or juvenile delinquency cases including supervision, education, or training of other persons providing such representation; or

c. who is employed as a full-time federal defense lawyer in a defender organization pursuant to 18 U.S.C.A. 2006A(g) that provides legal representation to indigent persons in criminal or juvenile delinquency cases.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

**§2005. Eligibility**

A. To establish eligibility, a lawyer must:

1. be employed full time as a public defender or prosecutor for at least one year as of December 31 of the year preceding the award; and

2. not be in default on any educational loan;

3. complete and submit an application by the deadline;

4. have the least ability to pay his student loans;
5. authorize LOSFA to access records held by any third party that will verify information provided on the application.

B. Upon notice from LOSFA that he must do so, the applicant must provide:

1. information necessary to substantiate information included on the application, including, but not limited to, the following:

- a. paycheck stubs for the two months immediately preceding the application date; and
- b. federal tax returns for the most recent tax year; and
- c. statements from all student loan holders evidencing the required monthly payments on his student loans;

2. a letter from his current employer verifying that the employer is an eligible employing entity under the John R. Justice Prosecutors and Defenders Incentive Act and recommending the applicant for participation in the program;

3. a completed John R. Justice Student Loan Repayment Program Service Agreement to LOSFA by the deadline.

C. Qualified lawyers are required to apply for participation each year. Prior year recipients will be given priority for participation in the program in the second and third year of the service obligation, provided the recipient continues to meet the requirements of §2005.A.1-4 and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

#### **§2007. Applicable Deadlines**

##### **A. Application Deadline**

1. Applicants must complete and submit the on-line application each calendar year no later than the deadline published by LOSFA.

2. Applications received after the deadline will not be considered unless there are insufficient qualifying applications received by the deadline to make awards for all eighteen grants.

3. In the event there are insufficient applications to award 18 grants, a second deadline will be announced.

4. In the event 18 grants cannot be awarded after a second application deadline has passed, LOSFA shall inform LASFAC and distribute the available remaining funds as directed by LASFAC.

B. Documentation Deadline. An applicant from whom documentation is requested must provide the required documentation within 45 days from the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

#### **§2009. Service Agreement**

A. An applicant who has been selected for participation must complete a John R. Justice Student Loan Repayment Program Service Agreement prior to the disbursement of any funds to his student loan holder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

#### **§2011. Responsibilities of LOSFA**

##### **A. LOSFA shall:**

1. evaluate documentation provided by applicants to substantiate the information provided on the application;

2. select program participants based on the documentation provided and the applicants' ability to pay student loans;

3. maintain program service agreements;

4. pay program funds to the program participant's eligible student loan holder with instructions that the funds are to be used to reduce the outstanding principal amount due on the loan(s);

5. maintain a secure database of all information collected on recipients and former recipients, including name, address, social security number, name of the institution(s) to which funds were disbursed, and amounts disbursed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

#### **§2013. Responsibilities of LASFAC**

##### **A. LASFAC shall:**

1. promulgate administrative rules in accordance with the Louisiana Administrative Procedure Act and in accordance with a federal grant from the United States Department of Justice to administer the John R. Justice Prosecutors and Defenders Incentive Act, 42 U.S.C.A. 3797cc-21 in Louisiana;

2. upon being informed by LOSFA that 18 grants cannot be awarded after a second application deadline has passed, establish a formula for apportionment of available remaining funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 37:

#### **Family Impact Statement**

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972.

#### **Small Business Statement**

The proposed Rule will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

#### **Public Comments**

Interested persons may submit written comments on the proposed changes (SG11126NI) until 4:30 p.m., February 10, 2010, to Melanie Amrhein, Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge  
General Counsel

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Scholarship/Grant Programs  
John R. Justice Grant Program**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The proposed rules implement the J. R. Justice Loan Forgiveness Program. Under this program, twelve (12) prosecutors will receive awards of \$5,000 each and six (6) public defenders will receive awards of \$10,000 each in 2011, based on an initial allocation of \$127,106 in federal funding from the U. S. Department of Justice. Louisiana may receive additional federal funding for subsequent awards, and no state general funds are required for this program.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

Revenue collections of state and local governments will not be affected by the proposed changes.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

The retention of experienced prosecutors and public defenders will benefit local citizens and families by increasing access to quality legal services for the poor, crime victims and their families.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There is no direct impact on competition or employment due to these changes.

George Badge Eldredge  
General Counsel  
1101#025

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Environmental Quality  
Office of the Secretary**

Green House Gases  
(LAC 33:III.111, 211, 223, 501,  
503, 523, 537, and 2132)(AQ315)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Air regulations, LAC 33:III.111, 211, 223, 501, 503, 523, 537, and 2132 (AQ315).

This Rule removes carbon dioxide (CO<sub>2</sub>) from the list of pollutants that "need not be included in a permit application." Also, a number of thresholds within the air quality regulations are currently set in terms of a source's emissions of "regulated pollutants" or "regulated air pollutants". These thresholds will be revised to be based on emissions of criteria and toxic air pollutants.

On April 2, 2010, EPA published a final Rule entitled "Reconsideration of Interpretation of Regulations That Determine Pollutants Covered by Clean Air Act Permitting Programs" (75 FR 17004). Under the terms of this action, greenhouses gas (GHGs) become "subject to regulation," and Title V and PSD program requirements begin to apply on January 2, 2011.

LAC 33:III.501.B.5, Item C.3 currently specifies that emissions of carbon dioxide (CO<sub>2</sub>) "need not be included in

a permit application." Information concerning potential emissions of GHGs, which includes CO<sub>2</sub>, will be necessary in order to assess major source status and applicability of the PSD program. GHGs also include nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride.

Further, as a consequence of GHGs becoming a "regulated" pollutant, revisions to other state air quality regulations will be necessary. This is because thresholds for small source permits, exemptions, insignificant activities, and General Condition XVII activities are dependent on a source's emissions of "regulated pollutants" or "regulated air pollutants". Moreover, whether a source can be classified as a small business is also based, in part, on its emissions of "regulated pollutants." Affected provisions include LAC 33:III.211.B.13.e, 223.Note 15, 501.B.2.d.i, 501.B.4.a.i, 501.B.5, 503.B.2, 523.A.1.b, 537.A.General Condition XVII, and 2132.A.Small Business Stationary Source.4 and 5.

Absent this regulatory change, fuel-burning equipment and other sources/activities emitting GHGs could no longer be considered as insignificant activities or General Condition XVII activities, nor could the facilities from which such emissions originate qualify for an exemption from the need to obtain an air permit, for a small source permit, or as a small business if they were otherwise eligible. The basis and rationale for this Rule are to ensure LDEQ can require CO<sub>2</sub> emissions data in air permit applications and to preserve existing thresholds within the air quality regulations once GHGs become "subject to regulation" on January 2, 2011. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

These proposed regulations are available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 N. Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

**Title 33  
ENVIRONMENTAL QUALITY  
Part III. Air**

**Chapter 1. General Provisions**

**§111. Definitions**

A. When used in these rules and regulations, the following words and phrases shall have the meanings ascribed to them below.

\* \* \*

*Criteria Pollutant*—any compound for which an ambient air quality standard has been listed in LAC 33:III.Chapter 7; however, *volatile organic compounds*, as defined in this Section, shall be included as a surrogate for ozone.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 14:348 (June 1988), LR 15:1061 (December 1989), amended by the

Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:777 (August 1991), LR 21:1081 (October 1995), LR 22:1212 (December 1996), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2444 (November 2000), amended by the Office of the Secretary, Legal Affairs Division, LR 32:808 (May 2006), LR 32:1599 (September 2006), LR 33:2082 (October 2007), LR 34:70 (January 2008), LR 35:1101 (June 2009), LR 36:1773 (August 2010), LR 37:

**Chapter 2. Rules and Regulations for the Fee System of the Air Quality Control Programs**

**§211. Methodology**

A. - B.13.d.iii. ...

e. Small Source Permit. The small source permit, as defined by LAC 33:III.503.B.2, applies when a permitted source is not a *Part 70 source* as defined in LAC 33:III.502. The permitted source must also emit or have the potential to emit less than 25 tons/year of any criteria pollutant, and less than 10 tons per year of any toxic air pollutant. For permit applications with processes specifically listed in the fee schedule that would also qualify for the small source permit fee, the permit fee shall be the lesser of these listed fees.

14. - 15.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 14:611 (September 1988), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:1205 (December 1991), LR 18:706 (July 1992), LR 19:1419 (November 1993), amended by the Office of Management and Finance, Fiscal Services Division, LR 22:17 (January 1996), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:264 (February 2000), LR 26:2444 (November 2000), LR 29:2776 (December 2003), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2435 (October 2005), LR 33:2082 (October 2007), LR 33:2620 (December 2007), LR 37:

**§223. Fee Schedule Listing**

Table 1. - Table 2.Note 14a. ...

Note 15. Applications must be accompanied by a certificate of eligibility authorized by the department's Small Business Technical Assistance Program. Final determination of a facility's eligibility is to be made by the administrative authority or his designee and may be based on (but not limited to) the following factors: risk assessment, proposed action, location, etc. For the purpose of this Chapter a small business is a facility which: has 50 employees or fewer; is independently owned; is a small business concern as defined pursuant to the Small Business Act; emits less than 5 tons/year of any single hazardous air pollutant and less than 15 tons/year of any combination of hazardous air pollutants; emits less than 25 tons/year of any criteria pollutant; has an annual gross revenue that does not exceed \$5,000,000; is not a major stationary source; and does not incinerate, recycle, or recover any off-site hazardous, toxic, industrial, medical, or municipal waste.

Note 16. - Note 20. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054, 2341, and 2351 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 14:613 (September 1988), LR 15:735 (September 1989), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:1205 (December 1991), repromulgated LR 18:31 (January 1992), amended LR 18:706 (July 1992), LR 18:1256

(November 1992), LR 19:1373 (October 1993), LR 19:1420 (November 1993), LR 19:1564 (December 1993), LR 20:421 (April 1994), LR 20:1263 (November 1994), LR 21:22 (January 1995), LR 21:782 (August 1995), LR 21:942 (September 1995), repromulgated LR 21:1080 (October 1995), amended LR 21:1236 (November 1995), LR 23:1496, 1499 (November 1997), LR 23:1662 (December 1997), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:267 (February 2000), LR 26:485 (March 2000), LR 26:1606 (August 2000), repromulgated LR 27:192 (February 2001), amended LR 29:672 (May 2003), LR 29:2042 (October 2003), LR 30:1475 (July 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 33:2620 (December 2007), LR 34:2560 (December 2008), LR 37:

**Chapter 5. Permit Procedures**

**§501. Scope and Applicability**

A. - B.2.d.i. ...

(a). five tons per year for each criteria pollutant as defined by the Clean Air Act;

2.d.i.(b). - 4.a. ...

i. the source emits and has the potential to emit no more than 5 tons per year of any criteria pollutant;

4.a.ii. - 5. ...

Table 1. Insignificant Activities List	
<b>A. Based on Size or Emission Rate</b>	Permit applications submitted under Subsection A of this Section for sources that include any of the following emissions units, operations, or activities must either list them as insignificant activities or provide the information for emissions units as specified under LAC 33:III.517:
1.	external combustion equipment with a design rate greater than or equal to 1 million Btu per hour, but less than or equal to 10 million Btu per hour, provided that the aggregate criteria pollutant emissions from all such units listed as insignificant do not exceed 5 tons per year;
2.	storage tanks less than 250 gallons storing organic liquids having a true vapor pressure less than or equal to 3.5 psia, provided that the aggregate emissions from all such organic liquid storage tanks listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any Minimum Emission Rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established pursuant to Section 112(g) of the federal Clean Air Act;
3.	storage tanks less than 10,000 gallons storing organic liquids having a true vapor pressure less than 0.5 psia, provided that the aggregate emissions from all such organic liquid storage tanks listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any Minimum Emission Rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established pursuant to Section 112(g) of the federal Clean Air Act;
4. - 5.	...
6.	emissions from laboratory equipment/vents used exclusively for routine chemical or physical analysis for quality control or environmental monitoring purposes, provided that the aggregate emissions from all such equipment vents considered insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any minimum emission rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established in accordance with Section 112(g) of the federal Clean Air Act;
7.	...
8.	portable fuel tanks used on a temporary basis in maintenance and construction activities, provided that the aggregate criteria or toxic air pollutant emissions from all such tanks listed as insignificant do not exceed 5 tons per year;
9.	emissions from process stream or process vent analyzers, provided that the aggregate emissions from all such analyzers listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any minimum emission rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established in accordance with Section 112(g) of the federal Clean Air Act;

<b>Table 1. Insignificant Activities List</b>	
10.	storage tanks containing, exclusively, soaps, detergents, surfactants, waxes, glycerin, vegetable oils, greases, animal fats, sweetener, molasses, corn syrup, aqueous salt solutions, or aqueous caustic solutions, provided an organic solvent has not been mixed with such materials, the tanks are not subject to 40 CFR 60, Subpart Kb or other federal regulation, and the aggregate emissions from all such tanks listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any minimum emission rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established in accordance with Section 112(g) of the federal Clean Air Act;
11.	catalyst charging operations, provided that the aggregate emissions from all such operations listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any minimum emission rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established in accordance with Section 112(g) of the federal Clean Air Act; and
12.	portable cooling towers used on a temporary basis in maintenance activities, provided the aggregate emissions from all such cooling towers listed as insignificant do not exceed 5 tons per year of criteria or toxic air pollutants, do not exceed any minimum emission rate listed in LAC 33:III.5112, Table 51.1, and do not exceed any hazardous air pollutant de minimis rate established in accordance with Section 112(g) of the federal Clean Air Act.
B. - B.46. ...	
C. Based on Type of Pollutant Emissions of the following pollutants need not be included in a permit application:	
1. - 2.	...
3.	nitrogen; and
4.	hydrogen.
D. Exemptions Based on Emissions Levels The owner or operator of any source may apply for an exemption from the permitting requirements of this Chapter for any emissions unit provided each of the following criteria are met. Activities or emissions units exempt as insignificant based on these criteria shall be included in the permit at the next renewal or permit modification, as appropriate.	
a.	The emissions unit emits and has the potential to emit no more than 5 tons per year of any criteria or toxic air pollutant.
b.	The emissions unit emits and has the potential to emit less than the minimum emission rate listed in LAC 33:III.5112, Table 51.1, for each Louisiana toxic air pollutant.
c.	The emissions unit emits and has the potential to emit less than the de minimis rate established pursuant to Section 112(g) of the federal Clean Air Act for each hazardous air pollutant.
a.	No new federally enforceable limitations or permit conditions are necessary to ensure compliance with any applicable requirement.

State or federal regulations may apply.

B.6. - C.13. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 and 2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:613 (July 1990), LR 17:478 (May 1991), LR 19:1420 (November 1993), LR 20:1281 (November 1994), LR 20:1375 (December 1994), LR 23:1677 (December 1997), amended by the Office of the Secretary, LR 25:660 (April 1999), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2445 (November 2000), LR 28:997 (May 2002), amended by the Office of Environmental Assessment, LR 31:1063 (May 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2436 (October 2005), LR 32:1842 (October 2006), LR 33:2082 (October 2007), LR 33:2626 (December 2007), LR 35:461 (March 2009), LR 35:2351 (November 2009), LR 37:

**§503. Minor Source Permit Requirements**

A. - B.1. ...

2. Small Source Permit. The owner or operator of a stationary source which is not a *Part 70 source* as defined in

LAC 33:III.502 may apply for a small source permit provided the source emits and has the potential to emit less than 25 tons per year of any criteria pollutant and 10 tons per year of any toxic air pollutant.

3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended by the Office of the Secretary, Legal Affairs Division, LR 37:

**§523. Procedures for Incorporating Test Results**

A. - A.1.a. ...

b. increases in permitted emissions will not exceed 5 tons per year for any criteria or toxic air pollutant;

A.1.c. - B.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended by the Office of the Secretary, Legal Affairs Division, LR 34:1903 (September 2008), LR 37:

**§537. Louisiana General Conditions**

A. ...

<b>Table 1. Louisiana Air Emission Permit General Conditions</b>	
I. - XVI.	...
XVII.	Very small emissions to the air, resulting from routine operations, that are predictable, expected, periodic, and quantifiable and that are submitted by the permitted facility to, and approved by, the Office of Environmental Services are considered authorized discharges. Approved activities are noted in the Louisiana General Condition XVII Activities List of the permit. To be approved as an authorized discharge, such very small releases must:
1.	generally be less than 5 TPY of criteria and toxic air pollutants;
2.	be less than the minimum emission rate (MER);
3.	be regularly scheduled (e.g., daily, weekly, monthly, etc.); or
4.	be necessary prior to plant start-up or after shutdown (line or compressor pressuring/depressuring, for example).
This Condition does not authorize the maintenance of a nuisance, or a danger to public health and safety. The permitted facility must comply with all applicable requirements, including release reporting requirements in LAC 33:1.Chapter 39.	
XVIII. - XX.	..

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011, 2023, 2024, and 2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, Legal Affairs Division, LR 35:660 (April 2009), amended LR 37:

**Chapter 21. Control of Emission of Organic Compounds**

**Subchapter F. Gasoline Handling**

**§2132. Stage II Vapor Recovery Systems for Control of Vehicle Refueling Emissions at Gasoline Dispensing Facilities**

A. Definitions. Terms used in this Section are defined in LAC 33:III.111 of these regulations with the exception of those terms specifically defined as follows.

\* \* \*

*Independent Small Marketer of Gasoline (ISBM)*—a person engaged in the marketing of gasoline who would be

required to pay for procurement and installation of vapor recovery equipment under this Section, unless such person:

- a. is a refiner; or
- b. controls, is controlled by, or is under common control with, a refiner; or
- c. is otherwise directly or indirectly affiliated with a refiner or with a person who controls, is controlled by, or is under a common control with, a refiner (unless the sole affiliation referred to herein is by means of a supply contract or an agreement or contract to use a trademark, trade name, service mark, or other identifying symbol or name owned by such refiner or any such person); or
- d. receives less than 50 percent of his annual income from refining or marketing of gasoline. The term *refiner* shall not include any refiner whose total refinery capacity (including the refinery capacity of any person who controls, is controlled by, or is under common control with, such refiner) does not exceed 65,000 barrels per day. Control of a corporation means ownership of more than 50 percent of its stock.

\* \* \*

*Small Business Stationary Source*—a stationary source that:

- a. is owned or operated by a person that employs 100 or fewer individuals;
- b. is a small business concern as defined in the Small Business Act;
- c. is not a major stationary source;
- d. does not emit 50 tons or more per year of any criteria or toxic air pollutant; and
- e. emits less than 75 tons per year of all criteria or toxic air pollutants.

\* \* \*

B. - I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 18:1254 (November 1992), repromulgated LR 19:46 (January 1993), amended LR 23:1682 (December 1997), LR 24:25 (January 1998), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2453 (November 2000), LR 29:558 (April 2003), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2440 (October 2005), LR 33:2086 (October 2007), LR 34:1890 (September 2008), LR 34:2397 (November 2008), LR 37:

#### **Family Impact Statement**

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

#### **Public Comments**

All interested persons are invited to submit written comments on the proposed regulations. Persons commenting should reference proposed regulations by AQ315. Such comments must be received no later than March 1, 2011, at 4:30 p.m., and should be sent to Donald Trahan, Attorney Supervisor, Office of the Secretary, Legal Affairs Division, Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to donald.trahan@la.gov. Copies of these proposed regulations can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of AQ315.

These proposed regulations are available on the internet at [www.deq.louisiana.gov/portal/tabid/1669/default.aspx](http://www.deq.louisiana.gov/portal/tabid/1669/default.aspx).

#### **Public Hearing**

A public hearing will be held on February 22, 2011, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 N. Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Donald Trahan at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

Herman Robinson, CPM  
Executive Counsel

### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Green House Gases**

#### **I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The proposed rule change may result in a minimal increase in Department of Environmental Quality administrative costs associated with reviewing and preparing Prevention of Significant Deterioration (PSD) permits for greenhouse gases. However, these costs will be offset with the surcharge associated with the PSD permit program.

#### **II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed rule change may result in an indeterminable increase in revenue collections due to receipt of fees associated with PSD permit applications for greenhouse gases. Any additional permit fees will be deposited into the Environmental Trust Fund.

#### **III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

The owner or operator of sources which emit or have the potential to emit carbon dioxide (CO<sub>2</sub>) will be affected by the proposed rule. The rule removes CO<sub>2</sub> from the list of pollutants that "need not be included in a permit application." Information concerning potential emissions of greenhouses gases (GHGs), which include CO<sub>2</sub>, will be necessary in order for LDEQ to assess major source status and applicability of the Prevention of Significant Deterioration (PSD) program once GHGs become "subject to regulation" on January 2, 2011. Thus, permit applicants will be required to calculate and include in permit applications estimates of CO<sub>2</sub> emissions.

Because permit applicants are already required to submit calculations addressing criteria and toxic air pollutants, determining emissions of CO<sub>2</sub> (which is necessary to quantify GHGs) should not be overly burdensome. Emission factors for CO<sub>2</sub> are generally available in AP-42, EPA's Compilation of Air Pollutant Emission Factors.

#### **IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There is no estimated effect on competition or employment in the public or private sector because of the proposed rule.

Herman Robinson, CPM  
Executive Counsel  
1101#057

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

## NOTICE OF INTENT

### Department of Environmental Quality Office of the Secretary

Organic Solvents; Emissions  
(LAC 33:III.2123)(AQ320)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Air regulations, LAC 33:III.2123.A (Log #AQ320).

This Rule will amend Subsection A of LAC 33:III.2123 by replacing language that was inadvertently removed in a previous rulemaking. This oversight needs to be corrected so the regulation will read accurately.

This proposed revision will also serve as a revision to the Louisiana Air Quality State Implementation Plan. The basis and rationale for this Rule are to mirror the control techniques guidelines issued by the EPA. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 N. Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 201 Evans Road, Bldg. 4, Suite 420, New Orleans, LA 70123.

#### Title 33

### ENVIRONMENTAL QUALITY

#### Part III. Air

### Chapter 21. Control of Emission of Organic Compounds

#### Subchapter B. Surface Coatings

#### §2123. Organic Solvents

A. Except as provided in Subsections B and C of this Section, any emissions source using organic solvents having an emission of volatile organic compounds resulting from the application of surface coatings equal to or more than 15 pounds (6.8 kilograms) per day, or an equivalent level of 2.7 tons per 12-month rolling period, shall control emissions of volatile organic compounds through the use of low solvent coatings, as provided in Subsection C of this Section, or, where feasible, by incorporating one or more of the following control methods:

A.1. - I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 16:119 (February 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:654 (July 1991), LR 18:1122 (October 1992), LR 22:340 (May 1996), LR 22:1212 (December 1996), LR 23:1678 (December 1997), LR 24:23

(January 1998), LR 24:1285 (July 1998), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:1240 (July 1999), LR 26:2453 (November 2000), LR 28:1765 (August 2002), LR 30:746 (April 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2440 (October 2005), LR 33:2086 (October 2007), LR 35:1102 (June 2009), LR 36:1774 (August 2010), repromulgated LR 36:2031 (September 2010), LR 37:

#### Family Impact Statement

This Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

#### Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by AQ320. Such comments must be received no later than March 1, 2011, at 4:30 p.m., and should be sent to Donald Trahan, Attorney Supervisor, Office of the Secretary, Legal Affairs Division, Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-4068 or by e-mail to donald.trahan@la.gov. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of AQ320. This regulation is available on the Internet at [www.deq.louisiana.gov/portal/tabid/1669/default.aspx](http://www.deq.louisiana.gov/portal/tabid/1669/default.aspx).

#### Public Hearing

A public hearing will be held on February 22, 2011, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 N. Fifth Street, Baton Rouge, LA 70802. The hearing will also be for the revision to the State Implementation Plan (SIP) to incorporate this Rule. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Donald Trahan at the address given below or at (225) 219-3985. Two hours of free parking are allowed in the Galvez Garage with a validated parking ticket.

Herman Robinson, CPM  
Executive Counsel

### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

#### RULE TITLE: Organic Solvents; Emissions

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will be no implementation costs or savings to state or local governmental units as a result of the proposed rule. This rule change merely replaces language which was inadvertently removed in a rule change in August 2010.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no estimated effect on revenue collections of state or local governmental units resulting from the proposed rule.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no significant costs and/or economic benefits to directly affected persons or non-governmental groups as a result of the proposed rule.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition or employment as a result of the proposed rule.

Herman Robinson, CPM  
Executive Counsel  
1101#058

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Office of the Governor  
Division of Administration  
Board of Cosmetology**

Exam Ineligibility and Alternative Hair Design  
(LAC 46:XXXI.310 and 1107)

The Board of Cosmetology does hereby give notice of its intent to enact a Rule (LAC 46:XXXI.310) regarding eligibility for examinations administered and to amend the Rule (LAC 46:XXXI.1107.A) regarding the educational requirements for alternative hair design permits.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part XXXI. Cosmetologists**

**Chapter 3. Schools and Students**

**§310. Ineligibility for Examination**

A. Ineligibility Period. Any individual who takes a written examination three times without receiving a passing score shall be ineligible to take any additional examinations until such time as the individual provides proof of completion of an additional 250 hours in the applicable curriculum at a cosmetology school approved by the board and provides a clearance from the school attended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:575(A)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Cosmetology, LR 37:

**Chapter 11. Special and Temporary Permits**

**§1107. Alternative Hair Design Curriculum**

A. Curriculum. The alternative hair design curriculum shall consist of at least 500 hours of instruction which shall include but not be limited to the following.

1. - 8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S.37:575(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Board of Cosmetology, LR 29:332 (March 2003), amended LR 37:

**Family Impact Statement**

Neither the proposed Rule nor the amended Rule should have any known or foreseeable impact on any family as defined by R.S. 49:972.D, or on family formation, stability and autonomy. There should be no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of persons regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children; or

6. the ability of the family or a local government to perform the function as contained in the proposed and amended rules.

**Public Comments**

Interested persons may submit written comments to Steven Young, Executive Director, Board of Cosmetology, 11622 Sunbelt Court, Baton Rouge, LA 70809, by facsimile to (225) 756-3410 or by email to DebryBlanchard.Legal@LA.gov by 8 a.m., February 14, 2011.

Steven Young  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Exam Ineligibility and  
Alternative Hair Design**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule change will have no impact on state or local government expenditures. The rule change provides for remedial education courses to help students pass the national standard test required to receive a license. All costs of remediation will be paid by students seeking licensure. The rule change will also reduce the number of hours required to receive a permit in the Alternative Hair Design curriculum.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will likely result in an indeterminable increase in the number of students that are licensed annually. Each additional student who becomes licensed as a result of this remediation will increase revenue to the Board of Cosmetology by \$25 per student. Any increase in the number of these permits is not anticipated to be significant.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will result in a decrease in the Alternative Hair Design curriculum of 500 hours (currently 1,000 hours). This will reduce the cost of this permit from \$8,000 to \$4,000. In addition, the rule change will provide remedial education for students seeking licensure. Remediation will be provided for \$8/hr. for 250 hours.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule could possibly provide 100 citizens per year an opportunity for a career path.

Stephen Young  
Director  
1101#047

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Office of the Governor  
Division of Administration  
Office of State Uniform Payroll**

403(b) Tax Shelter Annuity Program (LAC 4.III.901)

In accordance with the applicable provisions of R.S. 49:950 et seq., and pursuant to the authority granted under R.S. 42:455(A), the Division of Administration through the Office of State Uniform Payroll, finds it necessary to adopt

the following Rule. The Division of Administration, through the Office of State Uniform Payroll, finds that in excess of 260 non-university employees paid through the ISIS HR system working in the education field have voluntarily participated in Section 403(b) plans through direct payroll deductions as allowed by R.S. 42:455(A) without formally adopting conforming plans as required by IRS regulations. The rights and interests of these state employees, as well as other employees who may wish to participate, will be adversely affected unless the state provides for the establishment of a formally administered 403(b) Tax Shelter Annuity program which meets Internal Revenue Service regulations.

**Title 4**  
**ADMINISTRATION**  
**Part III. Payroll**

**Chapter 9. 403(b) Tax Shelter Annuity Program**

**§901. Establishment**

A. The following identified agencies may sponsor and participate in 403(b) plans for the benefit of their qualified education employees through payroll deductions and services afforded by the ISIS Human Resource System:

1. Board of Supervisors for the University of Louisiana System;
2. Louisiana School for the Deaf (renamed as Louisiana Schools for the Deaf and Visually Impaired);
3. Louisiana School for Math, Science and the Arts;
4. Board of Regents;
5. New Orleans Center for Creative Arts;
6. Louisiana Universities Marine Consortium;
7. Department of Education State Activities;
8. Recovery School District; and
9. any other ISIS HR paid agency which meets the Internal Revenue Code requirements applicable to 403(b) plans.

B. Each agency to sponsor a 403(b) plan shall sign an interagency agreement with the Division of Administration, agreeing to sponsor a 403(b) plan written to the agency's specifications. Each written plan, and any amendments made thereto, shall be approved as to form by the Commissioner of Administration through the Office of State Uniform Payroll and shall comply with this rule and all applicable IRS regulations. All plan agreements must be signed by the agency appointing authority and forwarded to the Office of State Uniform Payroll for review. The following plan options shall not be allowed: 1) Roth 403(b) contributions; 2) employer contributions; and 3) fifteen year service catch-up options. Any plan may provide for a distribution option at age 59 1/2. All plans shall allow participation by all eligible employees. Loan repayments shall not be handled through payroll deduction. Each agency, with oversight and approval of the Commissioner of Administration through the Office of State Uniform Payroll, shall administer its written 403(b) plan covering qualified ISIS HR paid education employees according to this rule.

C. The Office of State Uniform Payroll shall serve as the payroll agent/paymaster of the plan responsible for directing payroll deductions to the appropriate vendors. Agencies must work with the Office of State Uniform Payroll if a

desired vendor does not have a current payroll deduction. The Office of State Uniform Payroll shall delegate any responsibility for making all eligible employees aware of plan participation ("universal awareness") to each individual agency sponsoring a plan. All plans must be monitored for IRS compliance through a plan monitor approved by the Office of State Uniform Payroll. Any 403(b) plan sponsored shall be voluntary, shall be designated as non-ERISA, and shall be non-contributory on the part of any sponsor, employer or agency of the state.

D. Sponsoring agencies, in cooperation with the Division of Administration, are authorized to enter into contracts with commercially available plan monitors at no cost to the sponsor, employer or agency of the state, to assist in formulating, instituting and monitoring their 403(b) Tax Shelter Annuity plans. Once adopted, any 403(b) plan shall be managed by the sponsor in the best interests of the participating employees, subject to any rule or regulation adopted by the Division of Administration. Nothing shall prevent the Division of Administration from adopting emergency rules from time to time regarding the duties and operation of sponsored plans.

E. The Office of State Uniform Payroll may develop internal policies and forms whenever necessary to regulate the following:

1. submission of 403(b) plans and amendments for approval;
2. approval of 403(b) plan documents and amendments;
3. content and acceptance of interagency agreements;
4. approval of proposed vendors and plan monitors; and
5. payroll deductions.

F. If the Division of Administration determines that continued sponsorship of any 403(b) Tax Shelter Annuity plan for state employees paid through ISIS Human Resource System is not in the best interests of the state, it shall cause the sponsoring agencies to give adequate notice to the participants prior to terminating the plan, and shall cause the sponsoring agencies to comply with all applicable IRS regulations related to dissolving 403(b) plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:455 (A).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of State Uniform Payroll, LR 37:

**Family Impact Statement**

The proposed Rule has no known impact on family formation, stability, or autonomy. It has no known impact on the authority and rights of persons regarding the education and supervision of children, or the functioning of the family. The proposed Rule will have no adverse impact on family earnings and budget; it is believed that it will have a positive effect on the ability of the families affected to reduce federal income taxes and to save for retirement. It will have no adverse effect on the behavior and personal responsibility of children. The program proposed under the Rule cannot be performed solely by the family or through local government; it may only be performed through state government as required by law.

## Public Comments

Interested persons may submit written comments to Andrea P. Hubbard, Director of the Office of State Uniform Payroll, P.O. Box 94095, Baton Rouge, LA 70804-9095, until 5 p.m. on February 20, 2011.

Andrea Hubbard  
Director

## FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: 403(b) Tax Shelter Annuity Program

### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed Rule has no direct implementation costs or savings to state or local government units, and merely allows the continuance of an existing employee benefit program. Payroll deductions for §403(b) Tax Sheltered Annuities have been allowed in UPS and ISIS HR for many years. The Internal Revenue Service imposed stringent regulations and required these programs to be maintained in accordance with a written plan effective 12/31/2009. To avoid plan failures, effective 01/01/2010 the Division of Administration Office of State Uniform Payroll ceased all plan activities until plan documents could be finalized. Agencies are responsible for plan oversight and operations. The Division of Administration Office of State Uniform Payroll serves as payroll agent working with agencies, vendors, and the third party administrator to transfer payroll deductions and data. No new staff or personnel will be hired to implement or maintain the plan established by the Rule. The sponsored 403(b) plans are completely financed by the participating employees through payroll deductions, and are completely non-contributory on the part of the state or state agencies. It is estimated that \$1500 in expenses will be incurred with the publishing of this rule.

### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Reinstitution of the program will result in a minimal impact on state tax revenue. Revenue collections of local governmental entities will not be affected. Those state educational employees qualified to participate in 403(b) plans, like other IRS recognized deferred compensation plans, are entitled to shelter their payroll contributions from federal income taxes until a distribution of benefits occurs. The reduction of federal income tax liability of a participant may also reduce a participant's state income tax liability until benefit distribution occurs. It is estimated that 2000 state educational employees paid through the Office of State Uniform Payroll are eligible to participate in 403(b) plans. Historically, however, approximately 260 state employees of those eligible choose to participate.

### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Eligible state employees, under current law, may shelter up to \$16,500 for calendar year 2011 through participation in a 403(b) plan. The maximum tax shelter amount per calendar year for a 403(b) plan is determined annually by the Internal Revenue Service and is subject to change. If income is deferred, an employee may recognize a reduction in federal and state income taxes for the contribution year, and may invest and earn interest on the contributions for tax deferred retirement purposes. Deferred income and earned interest is not taxed until a distribution occurs. If a distribution occurs after retirement in accordance with IRS regulations, then a participant may be able to legally structure distributions in a manner that reduces federal and state income tax liabilities, and maximizes retirement income. The program has been inactive for nine (9)

months while institutions put plans in place. Had this not been done, a plan failure could have been cited by the Internal Revenue Service resulting in forced distribution of plan assets. This would have had significant tax implications for the employees involved.

### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed Rule is not anticipated to have an effect on competition and employment.

Stephen Procopio, Ph.D  
Assistant Commissioner  
1101#059

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

## NOTICE OF INTENT

### Office of the Governor Real Estate Appraisers Board

Appraisal Management Companies  
(LAC 46:LXVII.Chapters 301-309)

Under the authority of the newly enacted Appraisal Management Company Licensing and Regulation Act, R.S. 37:3415.1 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Louisiana Real Estate Appraisers Board has initiated procedures to enact LAC 46:LXVII, Professional and Occupational Standards, Real Estate, Subpart 3, Appraisal Management Companies, Chapters 301-309. These rules shall serve as an extension of the herein cited statute, which becomes effective January 1, 2011.

### Title 46

## PROFESSIONAL AND OCCUPATIONAL STANDARDS

### Part LXVII. Real Estate

### Subpart 3 Appraisal Management Companies

#### Chapter 301. Authority

#### §30101. Adoption; Powers of the Board

A. The rules and regulations of the Louisiana Real Estate Appraisers Board pertaining to the licensing and regulation of appraisal management companies have been adopted pursuant to and in compliance with R.S. 37:3415.1 et seq. Any violation of these rules and regulations shall be sufficient cause for any disciplinary action permitted by law.

B. The board shall have the full power and authority to:

1. regulate the issuance of appraisal management company licenses;
2. censure appraisal management company licensees; and
3. suspend or revoke appraisal management company licensees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

#### Chapter 303. Forms and Applications

#### §30301. Initial License Applications

A. Applications for initial licensing as an appraisal management company shall be in such forms and detail as prescribed by the board. Applicants shall submit all documentation requested on the application and shall adhere to any directions and deadlines prescribed therein.

B. Applications for initial licensing as an appraisal management company shall include, at a minimum, the following information:

1. the name, business address, telephone number, and the email address of the applicant;
2. the name, address, and contact information of each individual or entity that has any interest in the appraisal management company;
3. the name, address, and contact information of the controlling person, as defined by R.S. 37:3415.2;
4. the designation of an agent for service of process.

C. Applications for initial licensing as an appraisal management company shall include, at a minimum, the following certifications.

1. The applicant has a system in place to verify that all Louisiana appraisers on the panel of the appraisal management company are Certified Residential or Certified General Appraisers.

2. The applicant has a system in place to review the work of all independent appraisers performing appraisal services.

a. The appraisal services shall be conducted in conformity with the Uniform Standards of Professional Appraisal Practice.

b. All persons reviewing appraisals for the appraisal management company shall be certified appraisers in one or more states, or shall have received, or will receive, the 15-hour national Uniform Standards of Professional Real Estate Practice (USPAP) course, within six months after initial licensing.

3. The applicant will maintain a record of each request for appraisal services applicable to Louisiana properties, as well as the name of the independent appraiser that performs appraisal services, and the fee paid to the appraiser for each assignment.

4. The designated controlling person has accepted the responsibilities attendant to acting as such.

5. The applicant can attest to the good moral character of the individuals that are directed to manage the appraisal management company business.

D. Applications for initial licensing as an appraisal management company shall be submitted, at a minimum, with the following documentation:

1. a license history verification from each jurisdiction in which the applicant is currently licensed or has been licensed as an appraisal management company;

2. a copy of any trade name and trademark registration issued by the Louisiana Secretary of State for use by the applicant;

3. a copy of the resolution or other document executed by a principal of the appraisal management company designating a controlling person;

4. a copy of any corporation, partnership, or limited liability company registration certificate issued to the applicant by the Louisiana Secretary of State.

E. When an applicant has made a false statement of material fact on an initial license application or in any related document submitted therein, such false statement may in itself be grounds for refusal of an initial license.

F. If the board denies an application for initial licensing, the applicant shall be notified in writing and shall be

afforded an opportunity for a hearing before the board to show cause as to why the application should not be denied.

G. If the board determines that an applicant has satisfactorily met the prescribed requirements for initial licensing, a Louisiana appraisal management company license shall be issued to the applicant.

H. Initial licenses shall be issued for a period of 12 months and shall expire one year from the date the initial license is issued. Conducting any activity authorized by the license after the date of expiration shall be deemed a violation of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

### **§30303. License Renewal Applications**

A. Each appraisal management company license shall be renewed annually. Timely submission of a renewal application shall rest solely with the licensee.

B. The renewal application shall be in such form and detail as prescribed by the board and shall be accompanied by all documentation requested therein. Applicants for a renewal license shall adhere to all directions and deadlines prescribed within the application.

C. When an applicant has made a false statement of material fact on a license renewal application, or in any related document submitted therein, such false statement may in itself be grounds for refusal of a renewal license.

D. A licensee that fails to renew by the expiration date of the annual license shall be prohibited from operating as an appraisal management company in Louisiana until such time that the license has been renewed and any further requirements of the board have been met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

## **Chapter 305. Responsibilities and Duties**

### **§30501. Record Keeping**

A. Licensees shall maintain the following records in a complete and accurate manner:

1. all requests for appraisal services that have been referred to state certified real estate appraisers by the appraisal management company;

2. the amount of fees collected from borrowers or clients by the appraisal management company;

3. all payments made by the appraisal management company to any state licensed real estate appraiser;

4. any and all related documents, correspondence, accounts, reports, papers, books, or records.

B. All records shall be kept properly indexed and readily available to the board for review upon request and without prior notice. Duly authorized representatives of the board shall be authorized to inspect such records at the offices of licensees between the hours of 9 a.m. and 4 p.m., Saturdays, Sundays, and legal holidays excluded, and to subpoena any of the said records.

C. All records specified in this Chapter shall be retained for a period of five years; however, records that are used in a judicial proceeding, in which the appraiser provided testimony related to the appraisal assignment, shall be retained for at least two years after disposition, whichever period expires last.

D. At any time that a document or information on file with the board becomes inaccurate or incomplete, the appraisal management company shall notify the board in writing within five days.

E. An appraisal management company shall disclose to its client the actual fees paid to an appraiser for appraisal services separately from any other fees or charges for appraisal management services and, upon request, shall make that information available to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

### **Chapter 307. Prohibited Activities**

#### **§30701. Improper Influence**

A. Licensees shall not permit an agent, or anyone acting on behalf of the licensee, to engage in any of the following activities:

1. requiring the appraiser to collect the appraisal fee from a borrower, homeowner or third party;

2. hiring an employee or in any way contracting with or paying a real estate broker to perform a broker's price opinion or comparative market analysis unless the broker's price opinion or comparative market analysis is to be performed only for listing or selling property that the appraisal management company owns;

3. requiring the appraiser to provide the appraisal management company with the appraiser's digital signature or seal;

4. altering, amending, or changing an appraisal report submitted by a licensed or certified appraiser by removing the appraiser's signature or seal or by adding or removing information to or from the appraisal report;

5. removing an independent appraiser from the appraisal management company's panel without prior written notice that includes supporting evidence that:

a. the appraiser has acted illegally;

b. the appraiser has violated the Uniform Standards of Professional Appraisal Practice, or other applicable state statutes or rules; or

c. the appraiser has had substandard performances or otherwise acted in an improper or unprofessional manner.

6. entering into agreements with independent appraisers, unless the appraisers are licensed as a Residential Certified Real Estate Appraiser or General Certified Real Estate Appraiser and in good standing with the Louisiana Real Estate Appraisers Board;

7. requesting an appraiser to provide an estimated, predetermined, or desired value in an appraisal report or to provide estimated values or comparable sales at any time before the appraisal report is completed;

8. committing an act or practice that impairs, or attempts to impair, an appraiser's independence, objectivity or impartiality;

9. engaging an appraiser to appraise a property outside of his/her predominate appraisal practice locale, unless that appraiser has demonstrated competency for the assignment, specifically past appraisal experience in the market where

the property is located, and that there are no competent appraisers within the market where the property is located; or

10. making referrals to Louisiana appraisers for appraisal services during any period in which the appraisal management company license has expired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

### **§30703. Exemptions to Prohibited Activities**

A. It shall not be deemed a prohibitive activity to:

1. provide an appraiser with a copy of the sales contract for a purchase transaction;

2. request additional information from an independent appraiser about the basis for a valuation;

3. request that an independent appraiser correct factual errors in an appraisal report; or

4. request that an independent appraiser provide further substantiation, detail, or explanation for the appraiser's value conclusion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

### **Chapter 309. Disciplinary Authority; Enforcement and Hearings**

#### **§30901. Causes for Censure, Suspension, Revocation, or Denial of a License**

A. The Louisiana Real Estate Appraisers Board may censure, deny, suspend, or revoke an appraisal management company license, or may restrict or limit the activities of an appraisal management company or a person who owns an interest in or participates in the business of the appraisal management company, if the board finds that any of the following circumstances apply.

1. The application for licensing is found to contain statements that, in light of the circumstances under which they were made, are false or misleading with respect to a material fact.

2. The licensee has failed to comply with the rules and regulations of the board and/or the Louisiana Appraisal Management Company Licensing and Regulation Act.

3. The licensee's controlling principal has pled or been found guilty to a felony or within the past ten years has pled guilty or been convicted of a misdemeanor involving mortgage lending or real estate appraising or has committed an offense involving breach of trust, moral turpitude, fraudulent or dishonest dealings.

4. The licensee is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing to conduct any practice involving appraisal management services or operation of an appraisal management company.

5. The licensee is the subject of an order by the board denying, suspending, or revoking the licensee's privilege to operate as an appraisal management company in Louisiana.

6. The licensee acted as an appraisal management company while not properly licensed by the board.

B. Every licensee shall cooperate fully with and answer all questions propounded by the board personnel conducting an investigation.

C. Every licensee shall produce any document, book, or record in its possession or under its control, concerning any matter under investigation.

D. As a result of an investigation, when it appears that violations of the Louisiana Appraisal Management Company Licensing and Regulation Act and/or rules and regulations of the board may have been committed by a licensee, the violations may be adjudicated through informal or formal adjudicatory proceedings.

1. Informal Adjudicatory Proceedings

a. The complaint may be concluded informally without a public hearing on the recommendation of the hearing examiner and the concurrence of the executive director.

b. An informal hearing may be conducted only when there is an admission by the respondent that the violation(s) were committed as alleged.

c. A preliminary notice of adjudication shall be issued to advise the respondent of the violation(s) alleged and to advise the respondent that the matter can be resolved informally should the respondent desire to admit to committing the act(s) specified and submits a written request that the matter be resolved informally.

d. A hearing officer shall be appointed by the executive director to conduct an informal hearing with the respondent.

e. The informal hearing shall be attended by the hearing examiner and, if necessary, the case investigator, or in the absence of the case investigator, a designated representative. The hearing examiner shall inform the hearing officer of the administrative, jurisdictional, and other matters relevant to the proceedings.

f. Following an admission by the respondent that the violations were committed as alleged, the hearing officer may enter into a recommended stipulations and consent order to include the imposition of any sanctions authorized by the Louisiana Appraisal Management Company Licensing and Regulation Act.

g. No evidence will be presented, no witnesses will be called and no formal transcript of the proceedings will be prepared by the board.

h. In the written document the respondent must stipulate to having committed the act(s) in violation of the Louisiana Appraisal Management Company Licensing and Regulation Act and/or the rules and regulations of the board, accept the sanctions recommended by the hearing officer, and waive any rights to request a rehearing, reopening, or reconsideration by the board, and the right to judicial appeal of the consent order.

i. At the informal hearing, the respondent shall admit to having committed the act(s) specified, accept the sanctions recommended by the hearing officer, and waive the specified appellate rights, or the alleged violations shall be referred to a formal adjudicatory hearing.

j. If the respondent does execute a stipulation and consent order, the executive director shall submit the document to the board at the next regular meeting for approval and for authorization to allow the executive

director to execute the consent order in the name of the board.

k. Any consent order executed as a result of an informal hearing shall be effective on the date approved by the board.

2. Formal Adjudicatory Proceedings

a. All formal public adjudicatory hearings shall be conducted under the auspices of R.S. 37:3415.20 and the Administrative Procedure Act.

b. Board members who have provided technical assistance in any matter adjudicated at a formal adjudicatory proceeding shall recuse themselves and not participate in any portion of the proceedings.

c. The order issued by the board pursuant to any formal public adjudicatory proceeding shall become effective on the eleventh day following the date the order is issued by the board and entered into the record at the proceedings.

d. If a request for rehearing, reopening, or reconsideration of the order of the board is timely filed and denied by the board, the order shall become final on mailing of the notice of the board's final decision on the request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

**§30903. Appellate Proceedings**

A. Rehearings

1. An order of the board shall be subject to rehearing, reopening, or reconsideration by the board on receipt of a written request from a respondent. An application for rehearing, reopening, or reconsideration must be postmarked or received at the office of the board within 10 days from the date of entry of the order rendered by the board.

2. The date of entry is the date the order is issued by the board and entered into the record at the formal adjudicatory proceedings.

3. The request shall be reviewed by the board attorney for compliance with the Administrative Procedure Act. A finding by the board attorney that the request does not establish grounds for rehearing, reopening or reconsideration shall result in a denial of the request.

B. Judicial Review

1. Proceedings for judicial review of an order issued by the board may be instituted by filing a Petition for Judicial Review in the Nineteenth Judicial District Court in the Parish of East Baton Rouge.

2. In the event a request for rehearing, reopening or reconsideration has been filed with the board, the party making the request shall have 30 days from the final decision on the request within which to file a Petition for Judicial Review.

3. If a request for rehearing, reopening or reconsideration is not filed with the board, the Petition for Judicial Review must be filed in the Nineteenth Judicial District Court within 30 days after the mailing of the order of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

**§30905. Costs of Adjudicatory Proceedings**

A. On a finding that a respondent has committed the violation(s) as alleged in any formal or informal adjudicatory proceeding, the respondent may be assessed the administrative costs of the proceeding as determined by the board. Payment of these costs shall be a condition of satisfying any order issued by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

**§30907. Stay of Enforcement**

A. The filing of a petition for judicial review does not itself stay enforcement of an order issued by the board. A stay of enforcement will be granted only when directed by the court conducting a judicial review of adjudication.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3415.1 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Louisiana Real Estate Appraisers Board, LR 37:

**Family Impact Statement**

In accordance with R.S. 49:953(A)(1)(a)(viii) and 972, the following Family Impact Statement is submitted with the Notice of Intent for publication in the January 20, 2011 *Louisiana Register*: This proposed Rule has no known impact on family, formation, stability, or autonomy.

**Public Comments**

Interested parties are invited to submit written comments on the proposed regulations through February 3, 2011 at 4:30 p.m., to Stephanie Boudreaux, Louisiana Real Estate Commission, Box 14785, Baton Rouge, LA, 70898-4785 or to 9071 Interline Avenue, Baton Rouge, LA, 70809.

Bruce Unangst  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

**RULE TITLE: Appraisal Management Companies**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

Negligible implementation costs will be absorbed by the existing budget of the Louisiana Real Estate Appraisers Board. Office personnel will incorporate the administration of the new Appraisal Management Company licensing program within similar programs that are already administered by the board.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on revenue collections of state or local governmental units because there are no fees contained in the enabling statute (Act 502 Regular Session 2009).

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

The Appraisal Management Company (AMC) licensing program, enacted by Act 502 of the 2009 Regular Session, does not contain a fee schedule; therefore, their program will be administered at no cost to license applicants. The proposed rules assure real estate appraiser independence, flexibility, and efficiency, through the licensing and regulation of appraisal management companies. The rules serve to eliminate unsound business practices that have resulted in less credible real estate appraisals and uninformed underwriting decisions. Regulation of AMCs through these rules will provide proactive and necessary protection to homeowners and appraisers via a

framework for state registration and oversight, standards of ethical behavior, disclosure, accountability, reporting and recourse.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There is no estimated effect on competition and employment. The rules serve to ensure that appraisal management companies operate within the same basic guidelines and standards as state licensed independent real estate appraisers.

Bruce Unangst  
Executive Director  
1101#055

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Health and Hospital  
Board of Examiners in Dietetics and Nutrition**

Registered Dietitians (LAC 46:LXIX.Chapters 1-13)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:3085(4), that the Louisiana Board of Examiners in Dietetics and Nutrition intends to update the rules and regulations to reflect current requirements set forth by the Commission on Accreditation for Dietetics Education (CADE), so that applicants for a license are being held to national standards. Additionally, the board is requesting the addition of an Impaired Professional Program for licensees struggling with impairments such as, but not limited to, medical, mental, and substance abuse. Lastly, the board is requesting other "housekeeping" type amendments to revise language, not intent, of the Rule.

**Title 46**

**PROFESSIONAL AND OCCUPATIONAL  
STANDARDS**

**Part LXIX. Registered Dietitians**

**Chapter 1. Dietitians/Nutritionists**

**§101. Definitions**

A. As used in this Chapter, the following terms and phrases, which have not already been defined in the Practice Act, and R.S. 36:259(Q) and R.S. 37:3081-3094, shall have the meanings specified.

\* \* \*

*Applicant*—any person who has applied to the board for a license or permit to engage in the practice of dietetics/nutrition in the state of Louisiana.

\* \* \*

*Direct Supervision*—a licensed dietitian/nutritionist providing sufficient guidance and direction to enable a provisional licensed dietitian/nutritionist to perform competently.

\* \* \*

*Nutrition Counseling*—the provision of individualized guidance on appropriate food and nutrient intake for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychological facts from the nutrition assessment. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size or composition of meals; to modify food textures; and in extreme instances, to change the route of administration.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 25:1094 (June 1999), LR 37:

### **§103. Qualifications for Licensure**

A. - A.1. ...

2.a. Other persons applying for licensure must have earned a baccalaureate or post-baccalaureate degree, from the fields of human nutrition, food and nutrition, dietetics or food systems management, as well as receipt of the verification statement from a Commission on Accreditation for Dietetics Education (CADE) accredited program; or

b. Applicants who are not registered by CDR, but have a verification statement from a Commission on Accreditation for Dietetics Education (CADE) accredited program dated no later than five years.

3. Applicants who hold a doctorate degree granted prior to July 1, 1988, in addition to a baccalaureate or higher degree from a regionally accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, food systems management or biochemistry.

4. Repealed.

B. Professional Experience

1. Applicants who are currently registered by CDR are deemed to meet the academic requirements.

2. An applicant for licensure shall submit to the board evidence of having successfully completed a planned continuous supervised practice component in dietetic practice of not less than 1200 hours under the supervision of a registered dietitian or a licensed dietitian/nutritionist. The experience must be completed in the United States or its territories. Supervised dietetic practice accredited by CADE of the American Dietetic Association will be accepted in lieu of the board-approved plan.

C. Examination for Licensure

1. An applicant for licensure shall pass an examination administered by the Commission on Dietetic Registration.

2. Waiver of Examination

a. Persons who provide evidence of current registration with the Commission on Dietetic Registration as registered dietitians may be considered to have met the requirements for licensure.

b. Repealed.

D. Continuing Education Requirement

1. Requirements are considered to be met if a current CDR card is provided to the board annually.

2. The board has established a minimum requirement of 15 continuing education hours that must be completed annually in order to renew the dietitian/nutritionist license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 37:

### **§105. Qualifications for Reciprocity**

A. The board may grant a license by endorsement to any person who presents proof of current licensure as a dietitian or nutritionist in another state, District of Columbia, or territory of the United States which requires standards for licensure considered by the board to be equivalent to the requirements for licensure as prescribed in this Chapter.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 37:

### **§109. Application for Licensure**

A. - D. ...

E. The board will not consider an application complete until all information is received.

F. The board will send a notice to an applicant who does not complete the application in a timely manner, listing the additional materials required.

G. The application for a license shall contain such information as the board may reasonably require.

H. The submission of an application for licensing to the board shall constitute and operate as an authorization and consent by the applicant to the board to disclose and release any information or documentation set forth in or submitted with the applicant's application or obtained by the board from other sources as required.

I. An application who meets all the requirements of R.S. 41:37:3086 or 3087 and who has worked more than 30 days as a dietitian/nutritionist in the state of Louisiana and who has not otherwise violated any part of R.S. 41:3081-3094 or its rules and regulations, may be offered the following options in the form of a consent order and agreement to resolve the situation:

1. applicant is reprimanded for practicing as a Licensed Dietitian/Nutritionist in Louisiana without a license;

2. within 90 days of the date of the Consent Agreement and Order, applicant shall take and pass an open book examination covering the Louisiana Dietetic/Nutrition Practice Act and the board's rules and regulations to include Rules for Professional Conduct;

3. applicant must make a minimum score of 80 percent on the open book examination and will be allowed three hours to complete the examination at the board office. Applicant must pay applicable examination fee;

4. the consent agreement and order shall not be considered disciplinary action, but will be published by LBEDN.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 37:

### **§111. Issuance and Renewal of Licensure**

The board recognizes two distinct types of licensure. Applicants may be issued a regular license or a provisional license based on compliance with requirements stated in the

Dietetic/Nutritionists Practice Act and these regulations. The board shall issue a license to any person who meets the requirements upon payment of the license fee prescribed.

A. Regular License. The board may issue a regular license to any dietitian/nutritionist who qualified in accordance with the requirements of R.S. 37:3086(A), (B) or (C), and who practices in Louisiana, whether resident or nonresident, unless otherwise exempted as stated in R.S. 37:3093 of the Dietetic/Nutritionist Practice Act of 1987 and these regulations. The board will send each applicant whose credentials have been approved a license.

B. - B.1.b. ...

2. The board may issue a provisional license to a person before he has taken the exam prescribed by the board. A provisional license may be issued for a period not exceeding one year and may be renewed from year to year for a period not to exceed five consecutive years upon payment of an annual fee and presentation of evidence satisfactory to the board that applicant is meeting the supervision requirements and continuing education requirement of at least 15 hours or continuing education per license year.

C. - C.2. ...

D. Upgrading a Provisional License

1. The provisionally licensed dietitian/nutritionist shall submit to the board a written request, proof of successful completion of passage of the examination by CDR, as well as the upgrade fee.

2. When the upgrade occurs, the licensee shall be subject to the renewal requirements for a regular licensed dietitian/nutritionist.

E. - G.4. ...

5. has deliberately presented false information on application documents required by the board to verify the applicant's qualifications for licensure;

G.6. - H.1. ...

2. Licensee's application for renewal must be postmarked on or prior to the expiration date in order to avoid the late renewal fee. Failure to receive renewal notice shall not be justification for late renewal.

3. ...

4. Licensed Dietitian/Nutritionist

a. Licenses will expire annually on June 30, of every year.

b. Applicants receiving an initial license in the last quarter of the fiscal year (April, May, June) are not required to renew or provide proof of continuing education until the following licensing period.

5. Provisional License

a. Licenses will expire annually on June 30, of every year.

b. Applicants receiving an initial license in the last quarter of the fiscal year (April, May, June) will not be required to renew or provide proof of continuing education until the following one year licensing period.

6. Continuing Education Requirement for Renewing License

a. For renewal of a regular licensed dietitian/nutritionist license, licensees must submit proof of holding current CDR registration.

6.b. - 9. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January, 1984); amended by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:436 (July, 1988), LR 26:2613 (November 2000), LR 37:

#### **§112. Gratuitous Service during a Declared Public Health Emergency**

A. In a public health emergency lawfully declared as such by the Governor of Louisiana, the requirement for a Louisiana license as a licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist may be suspended by the board at that time to those out of state licensed dietitians/nutritionists or provisional licensed dietitian/nutritionists, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States, for a period of time not to exceed the duration and scope of R.S. 29:769(E), as more particularly set forth in this rule.

B. The following requirements for temporary registration may be imposed pursuant to the declared state of emergency and shall be in accordance with rules promulgated by the board.

C. A licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist not licensed in Louisiana, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States, may gratuitously provide dietetic/nutrition services if:

1. the licensed dietitian/nutritionist or provisional dietitian/nutritionist has photo identification and a license to verify a current and unrestricted license, certification or registration in another jurisdiction of the United States, and properly registers with the board prior to providing dietetic/nutrition services in Louisiana as follows:

a. the dietitian/nutritionist or provisional dietitian/nutritionist is engaged in a legitimate relief effort during the emergency period, and provides satisfactory documentation to the board of the location site(s) that he will be providing gratuitous dietetic/nutrition services;

b. the dietitian/nutritionist or provisional dietitian/nutritionist shall comply with the Louisiana Dietetic/Nutrition Practice Act, board rules and regulations, and other applicable laws, as well as practice in good faith, and within the reasonable scope of his skill, training, and ability; and

c. the dietitian/nutritionist or provisional dietitian/nutritionist renders services on a gratuitous basis with no revenue of any kind to be derived whatsoever from the provision of services within the state of Louisiana.

D. The authority provided for in the emergency rule shall be applicable for a period of time not to exceed 60 days at the discretion of the board, with the potential extension of up to two additional periods not to exceed 60 days for each extension as determined appropriate and necessary by the board.

E. All interested licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist shall submit a copy of their respective current and unrestricted licenses, certifications or registrations issued in other jurisdictions of the United States and photographic identification, as well as

other requested information, to the Louisiana Board of Examiners in Dietetics and Nutrition for registration with this agency prior to gratuitously providing dietetic/nutrition services in Louisiana.

H. Should a qualified licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist registered with the board thereafter fail to comply with any requirement or condition established by this rule, the board may terminate his registration upon notice and hearing.

G. In the event a licensed dietitian/nutritionist or provisional licensed dietitian/nutritionist fails to register with the board, but practices dietetics and/or nutrition, whether gratuitously or otherwise, then such conduct will be considered unlawful practice of dietetics and nutrition and prosecuted accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 37:

**§115. Denial, Suspension or Revocation of License**

A. Certificate denial, suspension or revocation shall be accomplished in accordance with section 3090(A) of R.S. 37:3081-3093, the state Administrative Procedure Act, and the procedural rules provided in Chapter 5 hereof.

B. The board may refuse to issue a license or provisional license, or suspend, revoke or impose probationary conditions and restrictions on the license or provisional license of a person on a finding of any of the causes provided by Section 3090(A) and (B) of the Dietitian/Nutritionist Practice Act.

C. A suspended license shall be subject to expiration and may be renewed as provided in this section, but such renewal shall not entitle the licensee, while the license remains suspended and until he is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order of judgment by which the license was suspended. If a license is revoked on disciplinary grounds and is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee and any late fee that may be applicable.

D. - D.6. ...

7. Restitution. Requirement imposed upon the licensee that he make financial or other restitution to a client, the board, or other injured party.

E. Publication of Disciplinary Action. The board will notify the professional community within 30 days of any disciplinary action, including the disciplined licensee's name, location, offense and sanction imposed. A notice of disciplinary action will also be published by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:438 (July 1988), amended LR 25:1095 (June 1999), LR 37:

**§119. General**

A. In accordance with the provisions of the Act, the following fees, where applicable, are payable to the board. All fees are nonrefundable.

Application Fee	\$45
Initial License Fee	45
Provisional License Fee	50
License Renewal Fee	60
Late Renewal Fee	25
Duplicate License Fee	25

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), repromulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), LR 26:2613 (November 2000), LR 37:

**Chapter 3. Board Members**

**§301. Board Members**

A. Officers. The board shall elect annually at the last meeting of the calendar year, a chairman, vice-chairman, and secretary/treasurer whose responsibilities are included in the policy manual.

B. Meetings

1. The board shall schedule meetings for the following calendar year at the last meeting of the current year.

2. A schedule of meeting dates shall be published.

3. Any board member who misses two board meetings, barring extenuating circumstances approved by the board, during the course of one calendar year shall resign from the board.

4. Special travel requests, other than regularly monthly meetings, must be approved by the board.

C. Expense Reimbursement

1. Expenses charged to the board must be consistent with the time frame and mission of board meetings and other functions. Expenses which are exceptions to this policy may be paid with justification and approval by the board.

2. Board members shall be reimbursed for actual traveling, incidental, and clerical expenses incurred while engaged in official duties.

a. Mileage expenses shall be reimbursed at the official state rate.

b. Airfare expenses must be at the state contract rate or economy class rate when contract rates are not available.

c. Lodging and meals shall be reimbursed at actual cost if receipts are submitted. Without receipts, lodging and meals shall be reimbursed at the appropriate state rate.

d. Incidental expenses are defined as telephone calls, fees for storage and handling of equipment, tips for baggage handling, parking fees, ferry fees, and road and bridge tolls.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 37:

**Chapter 5. Procedural Rules**

**§503. Investigation of Complaints**

A. - C. ...

D. The board's CIO shall have authority to investigate the nature of the complaint through conference and correspondence directed to those parties or witnesses involved. The officer shall send the involved licensee notice of the investigation, containing a short summary of the

complaint. All letters to the involved licensee, the complainant, or any other witness, shall be sent by certified mail, with the designation "Personal and Confidential" clearly marked on the outside of the envelope.

E. ...

F. The CIO shall make a recommendation to the board for disposition by informal hearing, formal hearing or dismissal of the complaint. When the CIO's recommended action might lead to denial, suspension, or revocation of the certificate, the board shall immediately convene a formal adjudication hearing, pursuant to R.S. 37:3090(B). The CIO may determine that the licensee's explanation satisfactorily answers the complaint and may recommend to the Board that the matter be dismissed. The recommended remedial action or dismissal of the complaint shall be forwarded to the involved complainant and licensee.

G. The CIO may also recommend to resolve the complaint through a consent order entered into by the licensee and the complainant. If the order contains any agreement by the licensee to some remedial course of action, the agreement must be signed by the complainant, the licensee and the board. The CIO will make note of any settlement arrived at between the complainant and the licensee, but such a settlement does not necessarily preclude further disciplinary action by the board.

H. - L. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1096 (June 1999), amended LR 37:

## **Chapter 7. Impaired Practitioner Program**

### **§701. Purpose and Scope**

A. Upon voluntary disclosure or proof that an applicant or licensee has provided professional services while under the influence of alcohol or has used narcotic or controlled dangerous substances or other drugs in excess of therapeutic amounts or without valid medical indication, the board may offer the applicant or licensee the Impaired Practitioner Program in order to receive or renew the professional license. Participation in the program may be required as a prerequisite to initial application for licensure or continued practice in accordance with the conditions of any consent order, compliance hearing, or adjudication hearing.

B. The board may utilize its discretionary authority to require or exclude specific components of this program for participants based upon determination of the nature and severity of the impairment. Participation in the Impaired Practitioner Program may consist of all or part of the following components:

1. a substance abuse assessment performed by a qualified, licensed health care professional within a prescribed period of time;

2. monitoring, including drug/alcohol screenings, with results submitted to the board, for a specified period of time. The frequency of screening and a deadline for submission of the screening results will also be specified. The name of the monitoring agency shall be submitted as requested by the board. Monitoring shall continue for a period of up to 36 months, as specified by the board;

3. suspension of the license or other action specified by the board upon receipt of any positive, unexplained screening results during the monitoring period;

4. mandatory weekly attendance at a self-help group such as Alcoholics Anonymous for a specified period of time. Submission of a monthly log which meets the board's specifications will be required:

a. a monthly log must be submitted to and received by the board before the final business day of the month following completion of the required meetings. It is the licensee's responsibility to ensure that these logs are properly completed and received by the board by the designated date;

b. the monthly log requires documentation of the first name and first initial of the last name of the sponsor, and meeting dates and times;

5. therapy for substance abuse by a licensed, health care professional;

6. supervision of the licensee by a supervisor approved by the board;

7. penalties for noncompliance as determined by the board.

C. The licensee will be responsible for executing all required releases of information and authorizations required for the board to obtain information from any monitor, treatment or service provider concerning the licensee's progress and participation in the program.

D. The applicant or licensee will bear the financial burden for all costs incurred in complying with the terms of assessments, supervision, drug/alcohol screens, and reproduction of treatment or other records.

E. The licensee shall notify the board office by telephone within 48 hours and in writing within five days of any changes of licensee's home address, telephone number, employment status, employer, supervisor, and/or change in practice at a facility.

F. In the event that a licensee relocates to another jurisdiction, the licensee will within five days of relocating be required to either enroll in the other jurisdiction's impaired practitioner program and have the reports required under the agreement sent to the board, or if the other jurisdiction has no impaired practitioner program, the licensee will notify the licensing board of that jurisdiction that the licensee is impaired and enrolled in the Louisiana program. In the event the licensee fails to do so, the license will be suspended.

G. Violation of the terms or conditions of the program may result in the immediate suspension of the individual's license to practice or other penalties for noncompliance.

H. The board will, to the full extent permissible, maintain an agreement or consent order relating to the licensee's participation in the Impaired Practitioner's Program as a confidential matter. The board retains the discretion to share information it deems necessary with those persons providing evaluation/assessment, therapy, treatment, supervision, monitoring or drug/alcohol testing or reports. Violation of any terms, conditions or requirements contained in any consent order, or board decision can result in a loss of the confidential status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 37:

**§703. Minimum Academic Requirements**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:13 (January 1984), repealed LR 37:

**Chapter 9. Dietitian Requirements**

**§901. Dietitian Requirements**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:14 (January 1984), repealed LR 37:

**Chapter 11. Louisiana Dietetic Association**

**§1101. Executive Board**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:14 (January 1984), repealed LR 37:

**Chapter 13. Enforcement**

**§1301. Enforcement**

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:14 (January 1984), repealed LR 37:

**Family Impact Statement**

The proposed changes may have impact on the family of dietitians/nutritionists that are referred to the Impaired Practitioner Program. The annual renewal requirement will have minimal impact on the family.

**Public Comments**

Interested persons may submit written comments to Emily Efferson, Administrator, 18550 Highland Road, Suite B, Baton Rouge, LA 70809. Written comments will be accepted through 4:30 p.m. on February 28, 2011.

Emily Efferson  
Administrator

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Registered Dietitians**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The Louisiana Board of Examiners in Dietetics and Nutrition is updating the Rules and Regulations to reflect current requirements set forth by the Commission on Accreditation for Dietetics Education (CADE), so that applicants for licensure are being held to national standards. However, there are no estimated costs to state or local governmental units as a result of these changes. There will be a one-time implementation cost of \$492.00 in FY 2011 for the cost of publishing the rule.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The board is proposing that all fees be non-refundable. Currently, the initial license fee, which is \$45.00, is refundable if the application is not approved. Only one or two applications are denied annually; therefore, this will not have a significant impact on revenue collections. The rule also changes the license renewal period from biennial to annual in order to align with the Practice Act under R.S. 37:3088. The Board has collected annual renewal fees for the past several years and will receive no increase in revenue as a result; the rule change is merely to align with current practice.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

Persons participating the Impaired Professional Program will be responsible for the costs of any tests, screenings, or therapy required by the Board for the program. The amount to be paid by program participants will be determined by the service providers' fees. Furthermore, with the rule change, any denied license applicant will no longer receive a return of the application fee (\$45).

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

Though the Board plans to implement the Impaired Professional Program, it is not expected to have a substantial effect on employment since the program's aim is rehabilitation. Only the most severe cases, as determined by the Board, will have their licenses revoked.

Emily Efferson  
Administrator  
1101#075

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Board of Veterinary Medicine**

Continuing Veterinary Medicine Education  
(LAC 46:LXXXV.400, 403, 409, 413, 811, and 1227)

The Louisiana Board of Veterinary Medicine proposes to amend and adopt LAC 46:LXXXV.400, 403, 409, 413, 811, and 1227 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 et seq., and the Louisiana Veterinary Practice Act, R.S. 37:1518(A)(9). The proposed rules are being amended and adopted to address the requirements and program approval of continuing veterinary medicine education necessary for annual renewal of a veterinary medicine license, registered veterinary technician certification, and animal euthanasia technician certification, in order to maintain and improve professional competencies for the health, welfare, and safety of the citizens and animals of Louisiana. Amended and adopted rules more clearly define protocol and standards for continuing education program approval. However, all other programs and/or their participants, including in-house programs, not addressed herein, shall be required to obtain pre-approval from the board in accordance with existing rules. Upon promulgation, the proposed Rule is intended to become effective for the period of time (July 1, 2010-June 30, 2011) for the 2011-2012 annual license and certification renewal and every annual license and certification renewal period thereafter.

**Title 46**  
**PROFESSIONAL AND OCCUPATIONAL**  
**STANDARDS**

**Part LXXXV. Veterinarians**

**Chapter 4. Continuing Veterinary Education**

**§400. Definitions**

\* \* \*

*Continuing Veterinary Education*—approved, accredited experience obtained from participation in post graduate veterinary studies, institutes, seminars, lectures, conferences, workshops, and other authorized forms of educational experiences so as to maintain and improve professional competencies for the health, welfare, and safety of the citizens and animals of Louisiana. A continuing veterinary education program accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, as well as those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board, shall be accepted as units or hours of continuing education; however, all other programs and/or their participants, including in-house programs, shall be required to obtain pre-approval from the board in accordance with LAC 46:LXXXV.409.A.3 and 4, respectively.

\* \* \*

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:224 (March 1990), amended LR 19:1427 (November 1993), LR 33:648 (April 2007), repromulgated LR 33:847 (May 2007), LR 37:

**§403. Continuing Veterinary Education Requirements**

A. a minimum of 20 actual hours is required each fiscal year (July 1 through June 30) as a prerequisite for annual renewal of a license. Hours may be taken from:

1. A continuing veterinary education program accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, as well as those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board; however, any other programs and/or their participants, including in-house programs, shall be submitted to the board for pre-approval of the units or hours of continuing education in accordance with LAC 46:LXXXV.409.A.3 and 4, respectively;

A.2. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518.

HISTORICAL NOTE: Promulgated as §405 by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:224 (March 1990), amended LR 19:1427 (November 1993), LR 23:1147 (September 1997), LR 28:1208 (June 2002), LR 33:649 (April 2007), repromulgated LR 33:847 (May 2007), LR 36:319 (February 2010), LR 37:

**§409. Approved Continuing Education Programs**

A. ...

1. All units or hours from contact participation programs listed on the pre-approved list of the board shall be accepted, as well as all units or hours from contact participation from programs accepted by another state's regulatory board of veterinary medicine, a governmental

entity, and/or AAVSB, as well as those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board.

2. The list of programs for which pre-approval has been granted will be updated as needed and published by the board on its website, as well as those programs which are accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, and those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board.

3. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:224 (March 1990), amended LR 19:1428 (November 1993), LR 33:649 (April 2007), repromulgated LR 33:848 (May 2007), LR 36:319 (February 2010), LR 37:

**§413. Non-Compliance**

A - D. ...

E. The promulgation of rule amendments by the board published in the *Louisiana State Register* on January 20, 2011 shall become effective for the period of time (July 1, 2010 - June 30, 2011) for the 2011-2012 annual license renewal and every annual license renewal period thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:225 (March 1990), amended LR 19:1428 (November 1993), LR 33:649 (April 2007), repromulgated LR 33:848 (May 2007), LR 36:320 (February 2010), LR 37:

**Chapter 8. Registered Veterinary Technicians**

**§811. Certificate Renewal, Late Charge, Continuing Education**

A. - C. ...

D. Continuing Education Requirements

1. ...

2. Any programs accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, as well as those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board shall be accepted as units or hours of annual continuing education. All other continuing education programs must be approved by the board prior to attendance with the subject matter content properly addressing the clinical practice of a registered veterinary technician. Those continuing education programs not timely submitted in accordance with Subsection F below will not be allowed for annual continuing education credit.

D.3. - E.2. ...

F. Approved Continuing Education Programs

1. Organizations sponsoring a continuing education program for RVTs which is required to obtain pre-approval must submit a request for approval of the program to the board no less than 14 days prior to the commencement of the program. Information to be submitted shall include:

- a. the name of the proposed program;
- b. course content; and

c. the number of continuing education units to be obtained by attendees.

2. RVTs may also submit a request for approval of a continuing education program which is required to obtain pre-approval, however, it must be submitted to the board no less than 14 days prior to the commencement of the program. Information to be submitted shall comply with the requirements of Paragraph F.1.

3. ...

G. The promulgation of rule amendments by the board published in the *Louisiana State Register* on January 20, 2011 shall become effective for the period of time (July 1, 2010 - June 30, 2011) for the 2011-2012 annual certificate renewal and every annual certificate renewal period thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1549.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 16:227 (March 1990), amended LR 23:1686 (December 1997), LR 26:84 (January 2000), LR 36: 320 (February 2010), LR 37:

## **Chapter 12. Certified Animal Euthanasia Technicians**

### **§1227 Continuing Education**

#### **A. Basic Requirements**

1. ...

2. Any programs accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, as well as those programs sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board shall be accepted as units or hours of annual continuing education. All other continuing education programs must be approved by the board prior to attendance.

3. Proof of attendance, which shall include the name of the course, date(s) of attendance, hours attended, shall be attached to the annual renewal form. Proof of attendance must include verification from the entity providing or sponsoring the educational program. However, the actual mediums of video tapes, self-test programs with third party grading, and/or self-help instruction, including online instruction, with third party grading, are limited to three hours per fiscal year period (July 1 through June 30). The requirement of pre-approval of the program by the board continues to apply for those programs not accepted by another state's regulatory board of veterinary medicine, a governmental entity, and/or AAVSB, as well as those programs not sponsored by AVMA accredited schools of veterinary medicine and/or any professional associations recognized by the board.

A.4. - B 2. ...

#### **C. Approved Continuing Education Programs**

1. Organizations sponsoring a continuing education program for CAETs which is required to obtain pre-approval must submit a request for approval of the program to the board no less than 14 days prior to the commencement of the program. Information to be submitted shall include:

a. - c. ...

2. CAETs may also submit a request for approval of a continuing education program which is required to obtain pre-approval, however, it must be submitted to the board no less than 14 days prior to the commencement of the

program. Information to be submitted shall comply with the requirements of Paragraph C.1.

3. ...

D. The promulgation of rule amendments by the board published in the *Louisiana State Register* on January 20, 2011 shall become effective for the period of time (July 1, 2010 - June 30, 2011) for the 2011-2012 annual certificate renewal and every annual certificate renewal period thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1558.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 26:321 (February 2000), amended LR 36: 320 (February 2010), LR 37:

#### **Family Impact Statement**

The proposed rules have no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

#### **Public Comments**

Interested parties may submit written comments to Wendy D. Parrish, Executive Director, Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA 70801, or by facsimile to (225) 342-2142. Comments will be accepted through the close of business on February 18, 2011. If it becomes necessary to convene a public hearing to receive comments in accordance with the Administrative Procedure Act, the hearing will be held on Thursday, February 24, 2011, at 10 am at the office of the Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA.

Wendy D. Parrish  
Executive Director

## **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

### **RULE TITLE: Continuing Veterinary Medicine Education**

#### **I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no costs or savings to state or local governmental units, except for those associated with publishing the amendment (estimated at \$400 in FY 2011). Licensees and certificate holders will be informed of this rule change via the board's regular newsletter or other direct mailings, and the Board's website, which result in minimal costs to the Board.

#### **II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no effect on revenue collections of state or local governmental units as no increase in fees will result from the amendment.

#### **III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NON-GOVERNMENTAL GROUPS (Summary)**

The proposed rules are being amended and adopted to address the requirements of continuing veterinary medicine education necessary for annual renewal of a veterinary medicine license, registered veterinary technician certification, and animal euthanasia technician certification. The amended rules will exempt from obtaining pre-approval from the Board those continuing education courses that are accepted by another state's regulatory board of veterinary medicine, a

governmental entity, and/or the American Association of Veterinary State Boards (AAVSB), as well as those programs sponsored by the American Veterinary Medical Association (AVMA) accredited schools of veterinary medicine, and/or any professional associations recognized by the Board. However, all other programs and/or their participants, including in-house programs, shall still be required to obtain pre-approval from the Board in accordance with existing rules. Upon promulgation, the proposed rules are intended to become effective for the period of time (July 1, 2010-June 30, 2011) for the 2011-2012 annual license and certification renewal and every annual license and certification renewal period thereafter. The proposed rules will facilitate the selection of Board approved continuing education courses which may be more cost effective.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

No impact on competition and employment is anticipated as a result of the proposed rule.

Wendy D. Parrish  
Executive Director  
1101#060

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

**Forensic Supervised Transitional Residential and  
Aftercare Facilities Minimum Licensing Standards  
(LAC 48:I.Chapter 72)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 48:I.Chapter 72 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 28:31. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 332 of the 2008 Regular Session of the Louisiana Legislature directed the Department of Health and Hospitals to adopt provisions governing the licensing standards for forensic supervised transitional residential and aftercare facilities. Forensic supervised transitional residential and aftercare facilities shall provide care and services to clients referred by state forensic hospitals or state forensic inpatient psychiatric units currently operated by the department. In compliance with the directives of Act 332, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which adopted provisions governing the minimum licensing standards for forensic supervised transitional residential and aftercare facilities (*Louisiana Register*, Volume 36, Number 6). The department subsequently amended the provisions of the July 1, 2010 Emergency Rule to clarify the criteria for clients served by these facilities (*Louisiana Register*, Volume 36, Number 9). This proposed Rule is being promulgated to continue the provisions of the September 20, 2010 Emergency Rule.

**Title 48**

**PUBLIC HEALTH—GENERAL**

**Part 1. General Administration**

**Subpart 3. Licensing and Certification**

**Chapter 72. Forensic Supervised Transitional  
Residential and Aftercare Facilities  
Licensing Standards**

**Subchapter A. General Provisions**

**§7201. Introduction**

A. These rules and regulations contain the minimum licensure standards for Forensic Supervised Transitional Residential and Aftercare (FSTRA) facilities, pursuant to R.S. 28:31-28:37. These licensing regulations contain core requirements as well as module specific requirements, depending upon the services provided by the Forensic Supervised Transitional Residential and Aftercare facility provider. The modules to be licensed under an FSTRA license are:

1. Secure Community Supervised Transitional/Residential Facility; and
2. Secure Forensic Facility.

B. A Forensic Supervised Transitional Residential and Aftercare facility serves clients referred by state forensic hospitals or state forensic inpatient psychiatric units operated by the Department of Health and Hospitals, including persons who are court ordered and persons who are on court ordered conditional release status. An FSTRA facility shall operate seven days per week, 24 hours a day.

C. The care and services to be provided through arrangement or by the FSTRA facility shall include, but are not limited to the following:

1. behavioral health services;
2. nutritional services;
3. medication management;
4. assistance with independent living skills;
5. recreational services; and
6. transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**§7203. Definitions**

*Administrator*—the person responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

*Behavior Management*—techniques, measures, interventions and procedures applied in a systematic fashion to promote positive behavioral or functional change which fosters the client's self-control, and to prevent or interrupt a client's behavior which threatens harm to the client or others.

*Department*—the Louisiana Department of Health and Hospitals.

*Forensic Clients*—persons transitioned from a forensic facility established pursuant to R.S. 28:25.1(A) or (B).

*Forensic Supervised Transitional Residential and Aftercare Facility*—a facility that provides supervised transitional residential and aftercare services to forensic

clients, including persons who are court ordered or who are on court ordered conditional release status. A forensic supervised transitional residential and aftercare facility shall provide clients, referred by state operated forensic facilities/hospitals and under court order or court ordered forensic conditional release, with individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community.

*Forensic Psychiatrist*—a physician, currently licensed to practice medicine in Louisiana, who:

1. signs the order admitting the individual to the FSTRA facility;
2. maintains overall responsibility for the client's medical management; and
3. is available for consultation and collaboration with the FSTRA facility staff.

*Licensee*—the person, partnership, company, corporation, association, organization, professional entity, or other entity to whom a license is granted by the licensing agency and upon whom rests the ultimate responsibility and authority for the conduct of and services provided by the FSTRA facility.

*Secure Community Supervised Transitional/Residential Facility*—a secure residential facility within the community that provides individualized services to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit. These services enable such persons to develop daily living skills and to prepare for vocational adjustment and reentry into the community.

*Secure Forensic Facility*—a secure residential facility located on the grounds of a state hospital that provides individualized services, including personal care services and medication administration, to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit. These services prepare such persons for transition to a less restrictive environment before transitioning to the community.

*Treatment Plan*—a comprehensive plan developed by the FSTRA facility for each client that includes the services each client needs. It shall include the provision of medical/psychiatric, nursing and psychosocial services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### §7205. Licensing Requirements

A. Any person or entity applying for an FSTRA license shall meet all of the core licensing requirements contained in this Subchapter as well as module specific requirements, unless otherwise specifically noted herein.

B. All facilities providing forensic supervised transitional residential and aftercare services shall be licensed by the department. An FSTRA facility shall not be established, opened, operated, managed, maintained, or conducted in this state without a license issued by the Department of Health and Hospitals. Each facility shall be separately licensed.

C. The Department of Health and Hospitals is the only licensing authority for FSTRA facilities in the State of Louisiana. It shall be unlawful to operate an FSTRA facility

without possessing a current, valid license issued by the department.

D. Each FSTRA license shall:

1. be issued only to the person or entity named in the license application;
2. be valid only for the facility to which it is issued and only for the specific geographic address of that facility;
3. be valid for one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;
4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the facility;
5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and
6. be posted in a conspicuous place on the licensed premises at all times.

E. In order for the FSTRA facility to be considered operational and retain licensed status, the facility shall meet the following conditions.

1. The facility shall provide 24-hour, seven days per week supervision consisting of:
  - a. at least three direct care staff persons during the day and two awake staff during the night;
  - b. at least two direct care staff persons in each building and/or unit at all times when clients are present; and
  - c. a functional security system on all points of ingress and egress with 24-hour, seven days per week monitoring by awake staff.

2. There shall be staff employed and available to be assigned to provide care and services to each client during all operational hours consistent with the behavioral health needs of each client.

3. The FSTRA facility shall have provided services to at least two clients in the preceding 12-month period in order to be eligible to renew its license.

F. The licensed FSTRA facility shall abide by and adhere to any state law, rules, policy, procedure, manual, or memorandums pertaining to such facilities.

G. A separately licensed FSTRA facility shall not use a name which is substantially the same as the name of another such facility licensed by the department, unless the facility is under common ownership with other FSTRA facilities.

H. No branches, satellite locations or offsite campuses will be authorized for an FSTRA facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### §7207. Initial Licensing Application Process

A. An initial application for licensing as an FSTRA facility shall be obtained from the department. A completed initial license application packet for an FSTRA facility must be submitted to and approved by the department prior to an applicant providing services. An applicant must submit a completed initial licensing packet to the department, which shall include:

1. a completed FSTRA facility licensure application and the non-refundable licensing fee as established by statute;
2. a copy of the approval letter of the architectural facility plans from the Office of the State Fire Marshal and any other office/entity designated by the department to review and approve the facility's architectural plans;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health;

5. a copy of the statewide criminal background checks on the following persons:

a. all individual owners with a 5 percent or more ownership interest in the FSTRA facility entity;

b. facility administrators; and

c. members of the facility's board of directors, if applicable;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least \$100,000;

b. general and professional liability insurance of at least \$300,000; and

c. worker's compensation insurance.

7. if applicable, Clinical Laboratory Improvement Amendments (CLIA) certificate or CLIA certificate of waiver;

8. a letter-sized floor sketch or drawing of the premises to be licensed; and

9. any other documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an FSTRA facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, notification of such approval shall be forwarded to the applicant. Within 90 days of receipt of the approval of the application, the applicant must notify the department that the FSTRA facility is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a licensed FSTRA facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

D. When issued, the initial Forensic Supervised Transitional Residential and Aftercare facility license shall specify the capacity of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§7209. Types of Licenses**

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the facility when the initial licensing survey finds that the facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes,

laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license unless the license is modified, revoked, or suspended.

2. Provisional Initial License. The department shall issue a provisional initial license to the facility when the initial licensing survey finds that the facility is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the individuals receiving services. The provisional license shall be valid for a period not to exceed six months.

3. Full Renewal License. The department shall issue a full renewal license to an existing licensed FSTRA facility which is in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license unless the license is modified, revoked, or suspended.

B. The department, in its sole discretion, may issue a provisional license to an existing licensed FSTRA facility for a period not to exceed six months for the following reasons.

1. The existing facility has more than five deficient practices or deficiencies cited during any one survey.

2. The existing facility has more than three validated complaints in one licensed year period.

3. The existing facility has been issued a deficiency that involved placing a client at risk for serious harm or death.

4. The existing facility has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey.

5. The existing facility is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

C. When the department issues a provisional license to an existing licensed FSTRA facility, the department shall conduct an on-site follow-up survey at the facility prior to the expiration of the provisional license, and shall issue written notice of the results of the follow-up survey.

1. If the on-site follow-up survey determines that the facility has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the facility license.

2. If the on-site follow-up survey determines that the facility has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal is filed pursuant to this Chapter.

a. At the sole discretion of the department, the provisional license may be extended for a period, not to exceed 90 days, in order for the FSTRA facility to correct the noncompliance or deficiencies.

D. When the department issues a provisional license as a result of the initial licensing survey, the facility shall submit

a plan of correction to the department for approval, and shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the facility prior to the expiration of the provisional license and shall issue written notice to the provider of the results of the follow-up survey.

1. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license will be issued.

2. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

a. At the sole discretion of the department, the provisional license may be extended for an additional period, not to exceed 90 days, in order for the FSTRA facility to correct the noncompliance or deficiencies.

E. The license for an FSTRA facility shall be valid for one year from the date of issuance, unless revoked, suspended, or modified prior to that time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7211. Licensing Surveys**

A. Prior to the initial license being issued to the FSTRA facility, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. The facility shall not provide services until the initial licensing survey has been performed and the facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. In the event that the initial licensing survey finds that the FSTRA facility is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider.

C. In the event that the initial licensing survey finds that the FSTRA facility is noncompliant with any licensing laws or regulations, or any other required statutes, laws, ordinances, rules or regulations, that present a potential threat to the health, safety, or welfare of clients, the department shall deny the initial license.

D. Once an initial license has been issued, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

E. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices.

1. An acceptable plan of correction may be required from an FSTRA facility for any survey where deficiencies have been cited.

2. If deficiencies have been cited, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

- a. civil monetary penalties;
- b. directed plans of correction; and
- c. license revocations.

F. DHH surveyors and staff shall be:

1. given access to all areas of the facility and all relevant files during any licensing or other survey; and
2. allowed to interview any provider staff, or client as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7213. Changes in Licensee Information or Personnel**

A. An FSTRA facility license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the FSTRA facility name, “doing business as” name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the occurrence. Any change regarding the facility name or “doing business as” name requires a change to the facility license and requires a \$25 fee for the reissuance of an amended license.

C. Any change regarding the facility’s key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel include the administrator, physician/psychiatrist and the registered nurse supervisor.

2. The facility’s notice to the department shall include the individual’s:

- a. name;
- b. facility address;
- c. hire date; and
- d. qualifications.

D. A change of ownership (CHOW) of the FSTRA facility shall be reported in writing to the department within five days of the change of ownership.

1. The license of an FSTRA facility is not transferable or assignable. The license of an FSTRA facility cannot be sold.

2. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

3. An FSTRA facility that is under license suspension, revocation, or denial of renewal may not undergo a CHOW.

E. Any request for a duplicate license shall be accompanied by a \$25 fee.

F. An FSTRA facility that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshall approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation the facility.

1. Written notice of intent to relocate shall be submitted to the licensing section of the department when plan review request is submitted to the department for approval.

2. The relocation of the facility's physical address results in a new anniversary date and the full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7215. Renewal of License**

A. License Renewal Application. The FSTRA facility shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;
2. a copy of the current on-site inspection with approval for occupancy from the Office of the State Fire Marshal;
3. a copy of the current on-site inspection report with approval of occupancy from the Office of Public Health;
4. proof of financial viability, comprised of the following:
  - a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least \$100,000;
  - b. general and professional liability insurance of at least \$300,000; and
  - c. worker's compensation insurance;
5. the license renewal fee; and
6. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license will result in the voluntary non-renewal of the Forensic Supervised Transitional Client and Aftercare license.

D. The renewal of a license or the denial of a renewal application does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7217. Denial of License, Revocation of License, Denial of License Renewal**

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for a license;
2. deny a license renewal; or
3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the FSTRA facility is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the clients who will be served by the facility.

2. The department may deny an initial license for any of the reasons in this Chapter that a license may be revoked or non-renewed.

#### **C. Voluntary Non-Renewal of a License**

1. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If a provider fails to timely renew its license, the facility shall immediately cease and desist providing services, unless the provider is actively treating clients, in which case the provider shall comply with the following:

- a. immediately provide written notice to the department of the number of clients receiving treatment at the FSTRA facility;
- b. immediately provide written notice to the prescribing physician and to the client or legal representative of the following:
  - i. notice of voluntary non-renewal;
  - ii. notice of closure; and
  - iii. plans for orderly transition of the client(s);
- c. discharge and transition of each client within 15 days of voluntary non-renewal; and
- d. notify the department of the location where records will be stored and the contact person for the records.

3. If an FSTRA facility fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning an FSTRA facility for a period of two years.

D. Revocation of License or Denial of License Renewal. An FSTRA facility license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the FSTRA facility licensing laws, rules and regulations, or with other required statutes, laws, ordinances, rules, or regulations;
2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's office, any regulatory agency, or any law enforcement agency;
3. failure to uphold clients' rights whereby deficient practices result in harm, injury, or death of a client;
4. negligent or harmful failure to protect a client from a harmful act of an employee or other client including, but not limited to:
  - a. mental or physical abuse, neglect, exploitation, or extortion;
  - b. any action posing a threat to a client's health and safety;
  - c. coercion;
  - d. threat or intimidation;
  - e. harassment; or
  - f. criminal activity;
5. failure to notify the proper authorities, as required by federal or state law, rules or regulations, of all suspected cases of:
  - a. mental or physical abuse, neglect, exploitation, or extortion;
  - b. any action posing a threat to a client's health and safety;
  - c. coercion;
  - d. threat or intimidation;

- e. harassment; or
  - f. criminal activity;
6. knowingly making a false statement in any of the following areas, including but not limited to:
- a. application for initial license or renewal of license;
  - b. data forms;
  - c. clinical records, client records or facility records;
  - d. matters under investigation by the department or the Office of the Attorney General; or
  - e. information submitted for reimbursement from any payment source;
7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;
8. the use of false, fraudulent or misleading advertising;
9. fraudulent operation of an FSTRA facility by the owner, administrator, manager, member, officer or director;
10. an owner, officer, member, manager, administrator, director or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court. For purposes of these provisions, conviction of a felony includes a felony relating to any of the following:
- a. violence, abuse, or negligence of a person;
  - b. misappropriation of property belonging to another person;
  - c. cruelty, exploitation, or sexual battery of a person with disabilities;
  - d. a drug offense;
  - e. crimes of sexual nature;
  - f. a firearm or deadly weapon;
  - g. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;
11. failure to comply with all reporting requirements in a timely manner as required by the department;
12. failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview provider staff or clients;
13. failure to allow or refusal to allow access to facility or client records by authorized departmental personnel; or
14. cessation of business or non-operational status.

E. If an existing FSTRA facility has been issued a notice of license revocation or suspension and the provider's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

F. If an FSTRA facility license is revoked or renewal is denied, (other than for cessation of business or non-operational status) any owner, officer, member, director, manager, or administrator of such FSTRA facility may be prohibited from opening, managing, directing, operating, or owning another FSTRA facility for a period of two years from the date of the final disposition of the revocation or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**§7219. Notice and Appeal of License Denial, License Revocation and License Non-Renewal and Appeal of Provisional License**

A. Notice of a license denial, license revocation or license non-renewal shall be given to the provider in writing.

B. An FSTRA facility has a right to an informal reconsideration of the license denial, license revocation, or license non-renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The FSTRA facility shall request the informal reconsideration within 10 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the facility will receive written notification of the date of the informal reconsideration.

4. The facility shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or non-renewal, shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The facility will be notified in writing of the results of the informal reconsideration.

C. An FSTRA facility has a right to an administrative appeal of the license denial, license revocation, or license non-renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The FSTRA facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or license non-renewal. The facility may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for administrative appeal shall be in writing and shall be submitted to the DHH Bureau of Appeals.

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the Bureau of Appeals, the administrative appeal of the license revocation or license non-renewal shall be suspensive, and the facility shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the facility pose an imminent or immediate

threat to the health, welfare, or safety of a client, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The facility shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or non-renewal, shall not be a basis for the administrative appeal.

D. If a timely administrative appeal has been filed by the facility on a license denial, license non-renewal, or license revocation, the Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals if good cause is shown.

1. If the final agency decision is to reverse the license denial, the license non-renewal or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to affirm the license non-renewal or the license revocation, the facility shall discharge any and all clients receiving services. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where its records will be stored.

E. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional license to a new FSTRA facility. A provider who has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license to an existing FSTRA facility is not considered to be a denial of license, a denial of license renewal, or a license revocation.

F. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The facility has five calendar days from the receipt of the department's notice of the results of the follow-up survey to submit a written request for informal reconsideration of the follow-up survey findings.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

4. The facility has five calendar days from the receipt of the department's notice of the result of the informal reconsideration to submit a written request for an administrative appeal. If the facility chooses not to request an informal reconsideration, the facility may submit a written request for an administrative appeal within five calendar days of receipt of the notice of the results of the follow-up survey.

G. A facility with a provisional license that expires under the provisions of this Chapter shall cease providing services

and discharge clients unless the Bureau of Appeals issues a stay of the expiration.

1. A stay may be granted by the Bureau of Appeals upon application by the provider at the time the administrative appeal is filed and only:

a. after a contradictory hearing; and

b. upon a showing that there is no potential harm to the clients being served by the facility.

H. If a timely administrative appeal has been filed by a facility with a provisional license that has expired under the provisions of this Chapter, the Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals if good cause is shown.

1. If the final agency decision is to remove all deficiencies, the facility's license will be reinstated upon the payment of any licensing or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to uphold the deficiencies and affirm the expiration of the provisional license, the facility shall discharge all clients receiving services. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§7221. Complaint Surveys**

A. The department shall conduct complaint surveys in accordance with R.S. 40:2009.13 et seq.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction may be required by the department for any complaint survey where deficiencies have been cited.

D. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The facility will be notified of any action.

E. The department may issue appropriate sanctions, including but not limited to, civil monetary penalties, directed plans of correction, and license revocations, for deficiencies and non-compliance with any complaint survey.

F. DHH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. DHH surveyors and staff shall be allowed to interview any provider staff, client, or participant, as necessary or required to conduct the survey.

G. An FSTRA facility which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as an administrative review. The facility or complainant shall submit all documentation or information for review for the informal reconsideration, and the department shall consider all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. Correction of the violation or deficiency shall not be the basis for the reconsideration. The facility and/or the complainant shall be notified in writing of the results of the informal reconsideration.

J. Except as provided in Paragraph K, the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

K. In those complaints in which the department's Health Standards Section determines that the complaint involves issues that have resulted in, or are likely to result in, serious harm or death to the client, the complainant or the provider may appeal the informal reconsideration findings to the Bureau of Appeals.

1. The written request for administrative appeal shall be submitted to the Bureau of Appeals and must be received within 30 calendar days of the receipt of the results of the informal reconsideration.

2. The hearing before the Bureau of Appeals is limited to the evidence presented at the informal reconsideration, unless the complainant or the facility has obtained additional evidence vital to the issues which he could not have with due diligence obtained before or during the informal reconsideration.

3. The administrative law judge shall only make a determination on the administrative appeal, based on the evidence presented, as to whether or not the complaint investigation or survey was conducted properly or improperly. The administrative law judge shall not have the authority to overturn or delete deficiencies or violations, and shall not have the authority to add deficiencies or violations.

4. If the administrative law judge determines that the complaint investigation or survey was not conducted properly, he shall designate in writing and with specificity the methods by which a re-investigation shall be conducted.

5. No appeal shall lie from a re-investigation upon a prima facie showing that the re-investigation was conducted in accordance with the designations of the administrative law judge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7223. Statement of Deficiencies**

A. The following statements of deficiencies issued by the department to an FSTRA facility shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to an FSTRA facility shall be available for disclosure to the public 30 calendar days after the provider submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in this Chapter, a facility shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the deficient practice, of the violation, or of the noncompliance shall not be the basis for the reconsideration.

2. The informal reconsideration of the deficiencies shall be requested in writing within 10 calendar days of receipt of the statement of deficiencies, unless otherwise provided for in these provisions.

3. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, revocations, and non-renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The facility shall be notified in writing of the results of the informal reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7225. Cessation of Business**

A. A facility that intends to close or cease operations shall comply with the following procedure:

1. give 30 days advance written notice to the:

- a. department;
- b. forensic physician; and
- c. ordering court of any conditional release client(s);

2. notify the department of the location where records will be stored and the contact person for the records; and

3. provide for an orderly discharge and transition of all clients admitted to the facility.

B. If an FSTRA facility fails to follow these procedures, the owners, managers, officers, directors and administrators may be prohibited from opening, managing, directing, operating or owning an FSTRA facility for a period of two years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **Subchapter B. Administration and Organization**

##### **§7231. Governing Body**

A. Each provider shall have an identifiable governing body with responsibility for, and authority over, the policies and activities of the program/facility.

B. A provider shall have documents identifying the following information regarding the governing body:

1. names and addresses of all members;
2. terms of membership;
3. officers of the governing body; and
4. terms of office of any officers.

C. When the governing body of a provider is comprised of more than one person, the governing body shall hold formal meetings at least twice a year. There shall be written minutes of all formal meetings and bylaws specifying frequency of meetings and quorum requirements.

D. When the governing body is composed of only one person, this person shall assume all responsibilities of the governing body.

E. Responsibilities of a Governing Body. The governing body of a provider shall:

1. ensure the provider's compliance and conformity with the provider's charter or other organizational documents;
2. ensure the provider's continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;
3. ensure that the provider is adequately funded and fiscally sound;
4. review and approve the provider's annual budget;
5. designate a person to act as Administrator and delegate sufficient authority to this person to manage the provider (a sole owner may be the administrator);
6. formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;
7. annually evaluate the administrator's performance (if a sole owner is not acting as administrator);
8. have the authority to dismiss the administrator (if a sole owner is not acting as administrator);
9. meet with designated representatives of the department whenever required to do so;
10. inform designated representatives of the department prior to initiating any substantial changes in the services provided by the provider; and
11. notify the Health Standards Section in writing at least 30 days prior to any change in ownership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§7233. Policy and Procedures**

A. An FSTRA provider shall establish procedures to assure written communication among staff to provide continuity of services to all clients.

B. Direct care employees shall have access to information concerning clients that is necessary for effective performance of the employee's assigned tasks.

C. Confidentiality and Security of Files. A provider shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records and to whom records may be released.

D. A provider shall allow designated representatives of the department, in the performance of their mandated duties, to inspect all aspects of a provider's functioning which

impact on clients and to interview any staff member or client.

1. A provider shall make any information or records that the provider is required to have and any information reasonably related to assessment of compliance with these requirements available to the department.

2. The client's rights shall not be considered abridged by this requirement.

E. Procedures shall address the following.

#### 1. Confidentiality of Records

a. A provider shall maintain the confidentiality of all clients' records. Employees of the facility shall not disclose or knowingly permit the disclosure of any information concerning the client or his/her family, directly, or indirectly, to any unauthorized person.

b. A provider may use material from records for teaching and research purposes, if names are deleted and other identifying information is disguised or deleted.

#### 2. Release of Information

a. A provider shall obtain the client's or legal representative's written, informed permission prior to releasing any information from which the client or his/her family might be identified, except to the department.

b. Identifying information may be given to appropriate authorities in cases of an emergency.

c. The provider shall have a procedure by which representatives or family of clients is given an opportunity to receive information about the individual client in care of the facility.

#### 3. Publicity

a. A provider shall have written policies and procedures regarding the photographing and audio or audiovisual recordings of clients.

b. No client shall be photographed or recorded without the client's prior informed, written consent. Such consent cannot be made a condition for admission into, remaining in, or participating fully in the activities of the facility.

i. Consent agreements must clearly notify the client of his/her rights under this regulation, must specify precisely what use is to be made of the photograph or recordings, and are valid for a maximum of one year from the date of execution.

ii. Clients are free to revoke such agreements at any time, either orally or in writing.

c. All photographs and recordings shall be used in a way that respects the dignity and confidentiality of the client.

F. Personnel Policies. A provider shall have written personnel policies that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members;

2. written job descriptions for each staff position including volunteers;

3. policies which provide for staff, upon offer of employment, to have a health assessment as defined in the provider's policy and procedures.

a. These policies shall, at a minimum, require that the individual has no evidence of active tuberculosis and that staff shall be retested on a time schedule as mandated by the Office of Public Health. Test results dated within one year

prior to the offer of employment are acceptable for initial employment;

4. an employee grievance procedure;
5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment whether that abuse or mistreatment is done by another staff member, a family member, a client, or any other person; and
6. a written policy to prevent discrimination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **Subchapter C. Admissions, Transfers and Discharges**

#### **§7235. Admissions**

A. The facility shall have a clear and specific written description of admission policies and procedures. This written description shall include, but is not limited to the following:

1. the application process and the possible reasons for the rejection of an application;
2. types of clients suitable to the FSTRA facility;
3. services offered and allowed in the facility; and
4. the facility's house rules.

#### **B. Intake Evaluation**

1. An intake evaluation shall take place on the first day of admission and shall include the client's:

- a. demographic data;
- b. family information; and
- c. psychiatric and social background.

2. All of the facility's rules and regulations shall be reviewed with the client. A complete clothing inventory shall be completed and the client shall be assigned to a room.

#### **C. Nursing Assessment**

1. The nurse shall complete a nursing assessment and review the client's medication(s). The client's medication administration records shall contain a detailed description of the client's:

- a. medication;
- b. dosage(s) of medication;
- c. frequency medications should be taken; and
- d. ability to self-administer medications.

#### **D. Diagnostic Evaluation**

1. The diagnostic evaluation shall include examination of the medical, psychosocial, social, behavioral and developmental aspects of the client's situation and reflect the need for services from an FSTRA facility.

2. Each medical evaluation shall include:

- a. diagnoses;
- b. summary of medical findings;
- c. medical history;
- d. mental and physical functional capacity;
- e. prognosis; and
- f. physician's recommendations.

E. An individualized plan of care for each client shall be developed upon admission and shall be revised to include recommended changes in the therapeutic plan. The plan to be followed in the event of emergency situations shall be specified in the plan of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7237. Mandatory Transfers and Discharges**

A. The administrator/director shall, in coordination with the client, forensic aftercare provider, Community Forensic Service, and state level forensic coordinator (as appropriate), assist in planning and implementing the mandatory transfer or discharge of the client when:

1. the treatment plan goals and objectives are substantially met and a crisis relapse/prevention plan is developed and support systems are in place that allow the client to reside safely in a less restrictive environment;

2. the client's physician certifies that the client's physical condition necessitates transfer to a medical facility or psychiatric condition necessitates transfer to a higher level of care; or

a. in this situation, plans for transfer must be made as soon as possible;

3. the client's condition is such that he or she is:

- a. a danger to self or others; or
- b. is consistently disruptive to the peace and order of the facility, staff services, or other clients.

B. Emergency Discharge. The provider shall immediately report to the Community Forensic Service, probation officer, state level forensic coordinator, and provider(s) of behavioral health services any program violations (i.e. illegal drugs, suspected or confirmed weapon possession or access, gross deterioration of behavior, or non-compliance with medication). The provider in collaboration with the probation officer and community forensic staff, as appropriate, will be responsible for the relocation of the client to an appropriate secure placement.

C. The facility shall initiate outpatient services for the client upon discharge and provide consultation to the client concerning where to obtain necessary medications, resources and follow-up outpatient behavioral health services.

#### **D. Discharge Records**

1. The following discharge information shall be recorded in the client's record:

- a. date of discharge;
- b. destination; and
- c. reason(s) for leaving.

2. Discharge records shall be retained for at least three years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **Subchapter D. Participation Requirements**

#### **§7241. Assessment, Service Coordination, and**

##### **Monitoring**

A. Once the client is admitted, the FSTRA facility shall conduct an assessment to determine the needs of the client. The assessment shall be kept in the client's record and shall at a minimum, include:

1. the client's interests, likes and dislikes;
2. review of physical health, psycho-social status, and cognitive status and the determination of services necessary to meet those needs;

3. a summary of the client's health needs, if any, including medication, treatment and special diet orders obtained from professionals with responsibility for the client's physical or emotional health;

4. a written description of the activities of daily living and instrumental activities of daily living for which the client requires assistance, if any, obtained from the client or the client's physician;

5. recreational and social activities which are suitable;

6. a plan for handling special emergency evacuation needs, if any; and

7. additional information or documents pertinent to the client's treatment planning, such as guardianship papers, power of attorney, living wills, do not-resuscitate orders, or other relevant medical documents.

B. Within 30 days after admission, the facility, with input from the client, shall develop a service plan using information from the assessment.

C. The service plan shall be responsive to the client's needs and preferences. The service plan shall include:

1. the client's needs;

2. the scope, frequency, and duration of services and monitoring that will be provided to meet the client's needs; and

3. staff/providers responsible for providing the services.

D. The client's service plan shall be revised when a client's condition changes. The revised service plan shall be signed by the client and the designated facility staff.

E. The service plan shall be monitored on an ongoing basis to determine its continued appropriateness and to identify when a client's condition or preferences have changed. A documented review of the service plan shall be made at least every quarter. However, changes to the plan may be made at any time, as necessary.

F. All service plans and reviews shall be signed by the client and facility staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7243. Personal and Supportive Services**

A. The facility shall provide adequate services and oversight/supervision, including adequate security measures, around the clock as needed for any client.

B. Medications

1. The provider shall have clear written policies and procedures on medication assistance.

2. The provider shall assist clients in the self-administration of prescription and non-prescription medication as agreed to in their contract or service plan and as allowed by state statute/regulations.

3. Assistance with self-administration of medications shall be limited to the following.

a. The client may be reminded to take his/her medication.

b. The medication regimen, as indicated on the container, may be read to the client.

c. The dosage may be checked according to the container label.

d. The staff may open the medicine container (i.e. bottle, mediset, blister pak, etc.) if the client lacks the ability to open the container.

e. The client may be physically assisted in pouring or otherwise taking medications, so long as the client is

cognitive of what the medication is, what it is for and the need for the medication.

4. An employee that provides assistance with the self-administration of medications to a client shall have documented training on the policies and procedures for medication assistance including the limitations of this assistance. Documentation shall include the signature of the employee. This training shall be repeated at least annually.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7245. Nutrition**

A. The facility shall provide three varied, appetizing meals a day, seven days a week. Meals shall take into account clients' preferences and needs.

B. Menus shall be planned and written at least one week in advance and dated as served. The current week's menu shall be posted in one or more conspicuous places in the facility.

C. The facility shall provide medically prescribed diets as ordered by the client's physician. These menus shall be planned or approved by a registered dietician.

D. The provider shall purchase and provide to the clients only food and drink of safe quality. The storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented. Milk and milk products shall be Grade A and pasteurized.

E. Staff shall be available in the dining area to provide supervision as needed.

F. Written reports of inspections by the Department of Health and Hospitals, Office of Public Health, Sanitarian Services shall be kept on file in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7247. Transportation Requirements**

A. The provider shall have the capacity to provide or to arrange transportation for the following:

1. transportation to behavioral health services (i.e., community mental health center or addictive disorder clinic); and

2. all other related medical appointments.

B. The FSTRA facility must:

1. have liability insurance coverage and have proof of such coverage; and

2. conform to all state laws and regulations pertaining to drivers, vehicles and insurance.

C. The number of occupants allowed in a car, bus, station wagon, van, or any other type of transportation shall not exceed the number for which the vehicle is designed.

D. Provisions shall be made to accommodate clients who use assistive devices for ambulation.

E. Each vehicle shall be maintained in good repair.

F. If the center contracts with a commercial proprietor for transportation, it shall select one with a good reputation and reliable drivers. All rules established for transportation furnished by the center shall be observed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## Subchapter E. Client Protection

### §7251. Client Rights

A. A provider shall have a written policy on clients' civil rights and the practices of the provider shall assure that no client of a facility shall be deprived of civil or legal rights, benefits or privileges guaranteed by law or the Constitution of the United States solely by reason of status as a client of a facility. A copy of these rights shall be posted conspicuously in the facility.

B. In addition to the basic rights enjoyed by other adults, the provider's written policy on rights shall assure that clients shall be afforded the rights enumerated in R.S. 28:171.

C. The client shall receive, upon admission and during his/her stay, a written statement of the services provided by the facility and the charges for these services.

D. The client shall be free from mental, emotional, and physical abuse and neglect and assured that no chemical restraints will be used.

E. The facility shall ensure that records and other information about the client are kept confidential and released only with a client's expressed written consent or in accordance with Louisiana law.

F. The facility shall ensure that the client:

1. receives a timely response to a request from the administrator/director and/or staff;
2. has access to private telephone communication;
3. is able to send and receive mail promptly and unopened;
4. is notified in writing by the provider when the facility's license status is suspended, revoked or limited, and to be informed of the basis of the licensing agency's action;
5. is allowed to select a health care provider and arrange for the services, at his/her own expense, which are not available through the facility as long as the client remains in compliance with the conditions of his/her admission to the facility;
6. is encouraged and assisted to exercise rights as a citizen;
7. is allowed to voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of restraint, interference, coercion, discrimination, or reprisal;
8. is fully informed of all client rights and all rules governing client conduct and responsibilities; and
9. is allowed to consult freely with counsel of their choice.

G. Each client shall be fully informed of these rights and of all rules and regulations governing client conduct and responsibilities, as evidenced by written acknowledgment, prior to or at the time of admission and when changes occur.

1. Each client's file shall contain a copy of the written acknowledgment which shall be signed and dated by the director or his/her designee, the client and/or representative.

H. A provider shall establish and have written grievance procedures that include, but are not limited to:

1. a formal process to present grievances; and
2. a process to respond to grievances in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

## Subchapter F. Facility Responsibilities

### §7255. General Provisions

A. Providers shall comply and show proof of compliance with all relevant standards, regulations and requirements established by state, local, and municipal regulatory bodies. It is the provider's responsibility to secure the approvals from the following entities:

1. DHH, Health Standards Section;
2. Office of Public Health;
3. Office of State Fire Marshal;
4. city fire department, if applicable; and,
5. the applicable local governing authority (e.g., zoning, building department or permit office).

B. The administrator/director or person authorized to act on behalf of the administrator/director shall be accessible to facility staff or designated representatives of DHH at all times.

C. A provider shall have an administrative file that includes:

1. the Articles of Incorporation or certified copies thereof, if incorporated, or partnership documents, if applicable;
2. a current copy of the approved constitution and/or bylaws of the governing body;
3. a current roster of the governing body membership which includes the members' addresses;
4. written policies and procedures approved by the owner/governing body that address the following:
  - a. confidentiality and security of files;
  - b. publicity;
  - c. personnel;
  - d. client's rights;
  - e. grievance procedure;
  - f. safekeeping of personal possessions, if applicable;
  - g. clients' funds, if applicable;
  - h. emergency and evacuation procedures;
  - i. abuse and neglect;
  - j. critical incidents;
  - k. admissions and discharge procedures; and
  - l. medication;
5. the minutes of formal governing body meetings;
6. an organizational chart of the provider;
7. all leases, contracts and purchase-of-service agreements to which the provider is a party, which includes all appropriate credentials;
8. insurance policies:
  - a. every provider shall maintain in force at all times a comprehensive general business insurance policy or policies in an amount adequate to cover all foreseeable occurrences. The insurance shall include coverage for any:
    - i. personal or professional negligence, malpractice or misconduct by facility owners or employees;
    - ii. injuries received by any client while being transported by facility staff or third-party contractors; and
    - iii. injuries sustained by any client while in the facility; and
  - b. the policies shall be without limitations or exclusions of any kind; and

9. copies of Incident/Accident Reports.

D. An FSTRA facility shall maintain a personnel record for each employee. At a minimum, this file shall contain the following:

1. the application for employment and/or résumé of education, training, and experience;
  2. evidence of a criminal history check prior to an offer of employment, in accordance with state law;
  3. evidence of applicable professional credentials or certifications according to state law;
  4. documentation of Tuberculosis test results and any other provider required medical examinations;
  5. documentation of three reference checks;
  6. annual performance evaluation;
  7. the employee's hire and termination dates;
  8. documentation of orientation and annual training;
- and
9. documentation of a valid driver's license if driving or transporting clients.

E. A provider shall not release an employee's personnel record without the employee's written permission, except as required by state law.

F. A provider shall have a personnel record for each employee to be kept on the premises or at the corporate office. These records shall be made available and accessible to the survey staff within one hour of request by department surveyors.

1. All records shall be maintained in an accessible, standardized order and format, and shall be retained and disposed of in accordance with state laws.

2. A provider shall have sufficient space, facilities and supplies for providing effective record keeping services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **§7257. Core Staffing Requirements**

A. Each FSTRA facility shall be staffed to properly safeguard the health, safety and welfare of the clients, as required by these regulations. At a minimum, the following staff positions are required; however, one person may occupy more than one position.

#### **B. Administrator/Director**

1. Each facility shall have a qualified administrator/director who is an on-site employee and is responsible for the day-to-day management, supervision and operation of the facility.

2. During periods of temporary absence of the administrator/director, there shall be a responsible staff person designated to be in charge that has the knowledge and responsibility to handle any situation that may occur.

3. There shall be a responsible staff person designated to be in charge on the premises of the FSTRA facility 24 hours per day.

4. The administrator/director shall be at least 21 years of age and have the responsibility and authority to carry out the policies of the facility.

5. The administrator/director shall meet one of the following criteria upon date of hire:

a. possess a bachelor's degree plus one year of administrative experience in the fields of health care, behavioral health services, or forensics;

b. possess an associate's degree plus two years of administrative experience in the fields of health care, behavioral health services, or forensics; or

c. in lieu of a degree, possess six years of administrative experience in health care, behavioral health services, or forensics.

6. Documentation of the administrator/director's qualifications shall be maintained on file at the facility.

#### **C. Nursing Services**

1. The facility shall provide a sufficient number of nursing service personnel consisting of registered nurses, licensed practical nurses and other staff to provide nursing care to all clients in accordance with the client's treatment plan.

2. Registered Nurse (RN). An FSTRA facility shall employ or contract with at least one RN who is responsible for the overall delivery and supervision of nursing services.

a. The RN must be currently licensed by, and in good standing with, the state of Louisiana and must comply with all requirements, including continuing education requirements, as established by law or regulation. No individual who is unlicensed may be employed as an RN.

b. The RN shall:

i. be on-site or available by telephone during the day time hours of the facility;

ii. develop policies and procedures related to the delivery of nursing services; and

iii. provide medication management through administration, supervision, education and training.

3. Licensed Practical Nurse (LPN). An FSTRA facility shall employ or contract with LPNs to meet the nursing needs of the clients.

a. The LPN must be currently licensed by, and in good standing with, the state of Louisiana and must comply with all requirements, including continuing education requirements, as established by law or regulation. No individual who is unlicensed may be employed as a LPN.

b. LPNs may administer medication and deliver nursing services as provided by Louisiana law or applicable regulations.

#### **D. Direct Care Staff**

1. An FSTRA facility must ensure that an adequate number of trained direct care staff is available to meet the needs of the clients in accordance with the client's scheduled and unscheduled needs.

2. Direct care staff may include care assistants, activities personnel, or other staff who clearly provide direct care services to clients on a regular basis.

3. Direct care staff shall have the following qualifications:

a. a minimum of a high school diploma and six months of experience working with adults with a serious and persistent behavioral health diagnosis; or

b. two years of experience working with adults with a serious and persistent behavioral health diagnosis.

4. An FSTRA facility shall have at least two direct care staff on duty when there is at least one client at the facility.

5. An FSTRA facility shall demonstrate that sufficient staff are scheduled and available (working) to meet the 24-hour scheduled and unscheduled needs of the clients. The

provider shall have at a minimum, one direct care staff person to every 15 clients.

6. An FSTRA facility shall not share direct care staff with another licensed facility. (Staff cannot fill two staff positions on the same shift at different licensed facilities.)

E. An FSTRA facility shall maintain a current work schedule for all employees, including relief workers, showing adequate coverage for each day and night.

F. FSTRA facility professional staff shall be licensed and/or certified by, and in good standing with, the state of Louisiana. The license shall be unrestricted. Professional staff must comply with all requirements, including continuing education requirements, as established by law or regulation.

G. Designated Recreational/Activity Staff. There shall be an individual designated to organize and oversee the recreational and social program of the facility.

H. An FSTRA facility must provide, as needed, consultation(s) with a registered dietician.

#### I. Staff Orientation and Training

1. During the first week of hire and prior to providing services to clients, the provider shall provide a 20-hour documented orientation including, but not limited to the following:

- a. the policies and procedures of the facility, including program components;
- b. emergency and evacuation procedures;
- c. training in proper fire and emergency safety procedures including:
  - i. CPR;
  - ii. the Heimlich Maneuver;
  - iii. first aid;
  - iv. crisis management; and
  - v. risk reduction;
- d. effective communication skills for forensic, behavioral health clients;
- e. confidentiality and HIPPA requirements;
- f. trainings and intervention programs as deemed appropriate and mutually agreed upon by Community Forensic Services and the state level forensic coordinator;
- g. client's rights; and
- h. procedures and requirements regarding the reporting of abuse, neglect and critical incidents.

2. Orientation for direct care staff shall include an additional five days of supervised training. Training, at a minimum, shall include the following:

- a. training in client care services (ADL'S & IADL'S) provided by the facility;
- b. infection control to include blood borne pathogens;
- c. crisis de-escalation and the management of aggressive behavior including acceptable and prohibited responses; and
- d. any specialized training to meet clients' needs.

3. A new employee shall not be given sole responsibility for the implementation of a client's program plan until this orientation and training is completed.

a. The staff member shall sign a statement certifying that such training has occurred and this shall be maintained in the staff members personnel file.

4. Orientation and five days of supervised training shall meet the first year's annual training requirements.

5. All direct care staff shall receive certification in adult first aid within the first 30 days of employment.

#### J. Annual Training

1. A provider shall ensure that each direct care worker participates in in-service training each year. Normal supervision shall not be considered as meeting this requirement.

2. The provider shall document that direct care staff receives training on an annual basis in:

- a. the facility's policies and procedures;
- b. emergency and evacuation procedures;
- c. client's rights;
- d. the procedures and legal requirements concerning the reporting of abuse and critical incidents;
- e. client care services (ADL'S & IADL'S);
- f. infection control to include blood borne pathogens; and
- g. any other areas that may require specialized training to meet clients' needs.

3. All direct care staff shall have documentation of current certification in first aid.

4. The administrator/director shall participate annually in at least 12 hours of continuing education in the field of behavioral health and specialized training in the population served and/or supervisory/management techniques.

5. Each employee shall sign a statement of understanding certifying that annual training has occurred.

K. An employee's annual performance evaluation shall include his/her interaction with clients, family, staff, and other providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7259. Client Records**

A. An FSTRA facility shall maintain a separate record for each client. Such records shall be current and complete and shall be maintained in the facility or in a central administrative location readily available to facility staff and to the department.

B. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of in accordance with state laws.

C. The facility shall have sufficient space, facilities, and supplies for providing effective record keeping services.

D. The facility shall have a storage area that ensures the safeguarding of all client records and prevents loss from, including but not limited, to fire or water.

E. Each record shall contain at least the following information:

1. the client's identifying and personal information including:
  - a. the client's name;
  - b. date of birth;
  - c. sex;
  - d. Social Security number;
  - e. previous home address; and
  - f. marital status, if applicable;
2. dates of admission and discharge;
3. names, addresses, and telephone numbers of responsible persons to be notified in case of accident, death or other emergency;

4. name, address, and telephone number of a physician and dentist to be called in an emergency;

5. ambulatory status;

6. the client's plan/authorization for routine and emergency medical care, as required;

7. the client's written authorization for a representative and their name, address and telephone number, if applicable;

8. the pre-admission assessment by a forensic physician and admission agreement;

9. findings of the assessment and any special problems or precautions identified;

10. the service plan, updates, and quarterly reviews;

11. continuing record of any illness, injury or medical or dental care when it impacts the client's ability to function or the services he/she needs;

12. a record of all personal property and funds which the client has entrusted to the facility;

13. reports of any client complaints or grievances and the conclusion or disposition of these reports;

14. incident reports; and

15. written acknowledgments that the client has received clear verbal explanations and:

a. copies of his/her rights and the house rules;

b. written procedures for safekeeping of valuable personal possessions of clients; and

c. a written statement explaining the client's rights regarding personal funds and the right to examine his/her record.

F. All information and records obtained from or regarding clients shall be stored and kept confidential.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7261. Abuse and Neglect**

A. The provider shall have comprehensive written procedures concerning client abuse and neglect to include provisions for:

1. training and maintaining staff awareness of abuse prevention, current definitions of abuse and neglect, reporting requirements and applicable laws;

2. ensuring that regulations stipulated in this rule for reporting critical incidents involving abuse and neglect are followed;

3. ensuring that the administrator/director completes an investigation report within 10 working days;

4. ensuring that the client is protected from potential harassment during the investigation;

5. disciplining staff members who abuse or neglect clients; and

6. protecting clients from abuse inflicted by other clients or third parties, including but not limited to, criminal prosecution of the offending person and his/her permanent removal from the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7263. Critical Incidents**

A. A provider shall have written procedures for the reporting and documentation of unusual incidents and other situations or circumstances affecting the health, safety or well-being of a client(s) (i.e. death by unnatural causes,

injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect).

1. Such procedures shall ensure timely verbal reporting to the director or designee and a preliminary written report within 24 hours of the incident.

2. Copies of all critical incident reports shall be kept as part of the client's record and a separate copy shall be kept in the administrative file of the provider.

B. Incident/Accident Report. When and if an incident occurs, a detailed report of the incident shall be made. At a minimum, the incident report shall provide documentation of the following:

1. the circumstances under which the incident occurred;

2. the date and time the incident occurred;

3. the location where the incident occurred (bathroom, bedroom, street, lawn, etc.);

4. immediate treatment and follow-up care;

5. the names and addresses of witnesses;

6. the date and time the family or representative was notified;

7. any symptoms of pain and injury discussed with the physician; and

8. the signatures of the staff completing the report, client, and director.

C. When an incident results in the death of a client, involves abuse or neglect of a client or entails any serious threat to the client's health, safety or well-being, a provider shall:

1. immediately report the incident verbally to the administrator and submit a preliminary written report within 24 hours of the incident;

2. immediately notify the Department of Health and Hospitals, Health Standards Section, and other appropriate authorities in accordance with state law, with written notification to the above agencies to follow within 24 hours of the suspected incident;

3. immediately notify the family or the client's representative, with written notification to follow within 24 hours;

4. immediately notify the appropriate law enforcement authority in accordance with state law;

5. provide follow-up written reports to all of the persons and agencies identified in this §7261.C;

6. take appropriate corrective action to prevent future incidents; and

7. document its compliance with all of the above procedures for each incident and shall keep such documentation (including any written reports or notifications) in the client's file. A separate copy of all such documentation shall be kept in the provider's administrative file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7265. Personal Possessions**

A. An FSTRA facility may, at its discretion, offer to clients the service of safekeeping their valuable possessions. The facility shall have a written statement of its policy.

B. If the facility offers such a service, a copy of the written policy and procedures shall be given to a client at the time of his/her admission.

C. The facility shall give the client a receipt listing each item that it is holding in trust for the client. A copy of the receipt shall be placed in the client's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7267. Client Funds**

A. The facility's admission agreement shall include the client's rights regarding personal funds and list the services offered and charges, if any.

B. The provider shall offer safekeeping and management of a client's funds. If a client chooses to entrust funds with the provider, the provider shall obtain written authorization from the client and/or his/her representative for the safekeeping and management of the funds.

C. The provider shall:

1. provide each client with an account statement on a quarterly basis with a receipt listing the amount of money the facility is holding in trust for the client;

2. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

3. provide a list or account statement regarding personal funds upon request of the client;

4. maintain a copy of each quarterly account statement in the client's record;

5. keep the funds received from the client in a separate interest-bearing account; and

6. not commingle the clients' funds with the facility's operating account.

D. The facility shall have and implement written policies and procedures to protect client funds.

E. Unless otherwise provided by state law, upon the death of a client, the provider shall provide the executor or administrator of the client's estate or the client's representative, as agreed upon in the admission agreement, with a complete account statement of the client's funds and personal property of the client being held by the provider.

F. A client with a personal fund account managed by an FSTRA facility may sign an account agreement acknowledging that any funds deposited into the personal account by, or on the client's behalf, are jointly owned by the client and his legal representative or next of kin. The account agreement must state that:

1. the funds in the account shall be jointly owned with the right of survivorship;

2. the funds in the account shall be used by, for or on behalf of the client;

3. the client or the joint owner may deposit funds into the account; and

4. the client or joint owner may endorse any check, draft or other monetary instrument to the order of any joint owner, for deposit into the account.

G. If a valid account agreement has been executed by the client, upon the client's death, the facility shall transfer the funds in the client's personal fund account to the joint owner within 30 days of the client's death. This provision only applies to personal fund accounts not in excess of \$2,000.

H. If a valid account agreement has not been executed, upon the client's death, the facility shall comply with the federal and state laws and regulations regarding the disbursement of funds in the account and the properties of the deceased. The facility shall abide by the procedures of the Louisiana Department of the Treasury and the Louisiana Uniform Unclaimed Property Act for the handling of funds of a deceased client that remain unclaimed.

I. The provisions of this Section shall have no effect on federal or state tax obligations or liabilities of the deceased client's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

J. A termination date of the account and the reason for termination shall be recorded on the client's participation file. A notation shall read, "to close account." The endorsed cancelled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7269. Contraband**

A. There shall be no contraband, illegal drugs, or controlled dangerous substances that are not prescribed to a client on the campus of the facility. Clients may be subjected to random periodic drug testing as a requirement for residency at the facility. A positive drug test will be reported to the attending psychiatrist and the applicable court.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **Subchapter G. Safety and Emergency Preparedness**

#### **§7271. General Provisions**

A. An FSTRA facility shall have an emergency preparedness plan designed to manage the consequences of natural disasters or other emergencies that could disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the clients and/or the community it serves. The emergency preparedness plan shall be made available, upon request or if mandated to do so, to local, parish, regional and/or state emergency planning organizations, the department and the Office of the State Fire Marshal.

B. At a minimum, the emergency preparedness plan shall include:

1. identification of potential hazards that could necessitate an evacuation, including internal and external disasters such as a natural disaster, acts of bioterrorism, weapons of mass destruction, labor work stoppage or industrial or nuclear accidents;

2. emergency procedures for evacuation of the facility;

3. procedures in the case of interruption of utility services in a way that affects the health and safety of clients;

4. identification of the facility and an alternate facility to which evacuated clients would be relocated;

5. the estimated number of clients and staff that would require relocation in the event of an evacuation;

6. the system or procedure to ensure that medical charts accompany clients in the event of a client evacuation

and that supplies, equipment, records and medications would be transported as part of an evacuation; and

7. the roles and responsibilities of staff members in implementing the disaster plan.

C. An FSTRA facility shall conduct and document fire drills once per month, one drill per shift every 90 days, at varying times of the day.

D. An FSTRA facility shall immediately notify the Health Standards Section and other appropriate agencies of any fire, disaster or other emergency that may present a danger to clients or require their evacuation from the facility.

E. The facility shall have access to 24-hour telephone service, and shall either post telephone numbers of emergency services, including the fire department, police department, medical services, poison control and ambulance services or show evidence of an alternate means of immediate access to these services.

F. General Safety Practices

1. The facility shall not maintain any firearm or chemical weapon in the living units of the facility.

2. The facility shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in a manner that ensures the safety of clients, staff and visitors.

3. The facility shall ensure that an appropriately equipped first aid kit is available in the living units and in all vehicles used to transport clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**Subchapter H. Physical Environment**

**§7275. General Provisions**

A. Location

1. The area to be licensed as an FSTRA facility shall meet all of the licensing regulations established for FSTRA facilities.

2. An FSTRA facility that is located within any other facility shall be secure and have its own identifiable staff, space and storage. The FSTRA facility shall have a separate entrance, separate dining area and separate common areas.

B. General Appearance and Conditions

1. Heating, cooling and ventilation systems shall permit comfortable conditions.

2. Furniture in good repair shall be available to facilitate usage by the number of clients in the facility.

3. The facility shall have sufficient space and equipment to accommodate the full range of program activities and services.

4. The facility shall be flexible and adaptable for large and small groups and individual activities and services.

5. There shall be sufficient office space to permit staff to work effectively and without interruption.

6. There shall be adequate storage space for program and operating supplies.

C. Interior Space

1. Floors and steps shall have a non-slippery surface and be dry when in use by the clients.

2. Doorways and passageways shall be kept clear to allow free and unhindered passage.

3. The facility shall provide an appropriate controlled-egress system on all required exit doors and doors leading to other areas of the facility unless prior approval of an alternative method for prevention of client elopement from the facility has been obtained from the authority (Office of the State Fire Marshal) having jurisdiction over such matters.

4. All staff shall have a key to locked exit doors.

5. All operable windows shall be equipped with a mechanism to limit exterior openings to prevent elopement.

6. Windows used for ventilation to the outside and exterior doors used for ventilation shall be screened and in good repair.

7. The facility shall be constructed, equipped, and maintained in good repair and kept free of hazards.

8. The facility shall have sufficient storage space for administration records, locked areas for medications, cleaning supplies (janitorial), food service (supplies) and lawn maintenance (equipment).

9. There shall be evidence of routine maintenance and cleaning programs in all areas of the facility.

10. The facility shall have an effective pest control program. Pest control services may be provided by maintenance personnel of the facility or by contract with a pest control company. If pest control chemicals are stored in the facility, they shall be kept in a locked location.

11. The facility shall have an area for the safe and secure maintenance and storage of medical records and other facility files, records and manuals.

D. Bedrooms

1. Single rooms must contain at least 100 square feet and multi-bed rooms shall contain at least 80 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment. An existing state hospital that converts a building, unit or wing to an FSTRA facility shall contain a minimum of 65 square feet per bed in a multi-bed room.

2. Any client room shall not contain more than four beds.

a. Beds shall be of solid construction, appropriate to the size and age of the client and have a clean, comfortable, non-toxic fire-retardant mattress that fits the bed.

b. Cots or other portable beds are to be used in emergencies only.

3. Rooms shall have at least a 7 1/2 foot ceiling height over the required area.

a. In a room with varying ceiling heights, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space.

4. There shall be at least three feet between beds.

5. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of clients.

6. Doors to individual bedrooms shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

7. The provider shall not use any room that does not have a window as a bedroom space.

8. The facility shall provide sheets, pillows, bedspreads and blankets that are in good repair for each client. Linens not in good repair shall not be used.

9. Each client shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the client.

10. The facility shall not have male and female clients at the same location.

#### E. Bathrooms

1. The number of toilets and hand-washing facilities shall be not less than one for each 13 clients.

2. A facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to client care needs.

3. Bathrooms shall be so placed as to allow access without disturbing other clients during sleeping hours.

4. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene, unless clients are individually given such items.

a. Clients shall be provided individual items such as hair brushes and toothbrushes.

5. Tubs and showers shall have slip proof surfaces.

6. An FSTRA facility shall have toilets and baths or showers that allow for individual privacy, unless the clients in care require assistance.

7. Toilets, wash basins and other plumbing or sanitary facilities in an FSTRA facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

8. The facility shall have separate toilet facilities for staff.

#### F. Furnishings

1. The facility shall be furnished so as to meet the needs of the clients. All furnishings and equipment shall be kept clean and in good repair.

2. Adequate furniture shall be available and shall be appropriate for use by the clients in terms of comfort and safety.

3. Furnishings must include tables and chairs sufficient in number to serve all clients.

#### G. Kitchen

1. An FSTRA facility that has a kitchen area shall meet all health and sanitation requirements and must be of sufficient size to accommodate meal preparation for the proposed number of clients.

2. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving and storage and clean up of all meals regularly served to all of the clients and staff. All equipment shall be maintained in proper working order.

3. An FSTRA facility's refrigerator(s) shall be maintained at a temperature of 45 degrees Fahrenheit or below. Freezers shall be maintained at a temperature of 0 degrees Fahrenheit or below. Thermometers shall be provided for all refrigerators and freezers. The facility shall maintain logs of temperatures of the refrigerator and freezers. Abnormal temperatures shall be reported to management and arrangements made for repair/service.

4. The facility shall ensure that all dishes, cups and glasses used by clients are free from chips, cracks or other defects and are in sufficient number to accommodate all clients.

5. If food is prepared in a central kitchen and delivered to the facility, provisions shall be made and approved by the Department of Health and Hospitals, Office of Public Health, Sanitarian Services for proper maintenance of food temperatures and a sanitary mode of transportation.

#### H. Medication Storage and Monitoring

1. The facility shall have policies and procedures for the storage, administration and disposal of both prescription and over-the-counter medications.

2. There shall be a designated secure area for the storage and preparation of medications.

3. Medications that require refrigeration shall be stored in a separate refrigerator (not with food, beverages, etc.).

4. The FSTRA shall have a process for monitoring the inventory and reconciliation of controlled substances. The process shall include the reporting of lost or missing medications in accordance with the Louisiana State Board of Pharmacy.

5. Medications may be administered from a central area of the facility.

#### I. Laundry

1. An FSTRA facility shall provide for laundry services, either on-site or at an off-site location that is adequate to handle the needs of the clients.

2. If on-site, laundry facilities shall be located in a specifically designated area and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material.

3. Laundry rooms shall not open directly into client common areas or food service areas.

4. Domestic washers and dryers that are for the exclusive use of clients may be located in client areas, provided they are installed in such a manner that they do not cause a sanitation problem.

#### J. Water Supply

1. An adequate supply of water, under pressure, shall be provided at all times.

2. Clean sanitary drinking water shall be available and accessible in adequate amounts at all times. Disposable cups, if used, shall be stored in such a way as to prevent contamination.

3. When a public water system is available, a connection shall be made thereto. If water from a source other than a public water supply is used, the supply shall meet the requirements set forth under the rules and regulations of the Office of Public Health (OPH).

4. The facility shall have a plan and policy for an alternative water supply in the event of interruption of water supply and for the prolonged loss of water.

#### K. All sewage shall be disposed of by means of either:

1. a public system where one is accessible within 300 feet; or

2. an approved sewage disposal system that is constructed and operated in conformance with the standards established for such systems by OPH.

#### L. Facility Exterior

1. The provider shall maintain all areas of the facility that are accessible to the clients in good repair and free from any reasonably foreseeable hazard to health or safety.

2. All structures on the grounds of the facility shall be maintained in good repair.

3. Garbage and rubbish stored outside shall be secured in noncombustible, covered containers and shall be removed on a regular basis.

4. Fences shall be in good repair and constructed in such a way as to provide security.

5. Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced or have natural barriers to protect clients.

6. Clients shall have access to safe, suitable outdoor recreational space.

7. The facility shall ensure that exterior areas are well lit at night.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **Subchapter I. Secure Community Supervised Transitional/Residential Facility Module**

#### **§7279. General Provisions**

A. Providers applying for the Secure Community Supervised Transitional/Residential (SCSTR) Facility module under the FSTRA facility license shall meet the core licensing requirement as well as the following module specific requirements.

B. A secure community supervised transitional/residential facility is a secure residential facility within the community that provides individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community, to persons who are under a court-ordered forensic conditional release and who are referred by a state forensic hospitals or state forensic psychiatric unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7281. Operational Requirements**

##### **A. Staff Requirements**

1. The FSTRA-SCSTR facility shall provide 24-hour, seven day per week "supervision" consisting of at least three direct care staff persons during the day, one of which must be a licensed nurse and at least two awake staff during the night.

2. The FSTRA-SCSTR facility shall have a licensed nurse on call when there are no licensed nurses on duty at the facility.

##### **B. Admissions. The SCSTR facility shall:**

1. only accept clients referred by DHH state forensic facilities or those who are under a court-ordered forensic conditional release;

2. admit only those clients who have the ability to self administer medications and provide for their own personal care needs;

3. not admit more clients into care than the number specified on the FSTRA facility's license; and

4. provide contact information, including the telephone number and mailing address, for the appropriate state protection and advocacy organization.

##### **C. Medication Administration**

1. The facility shall have clear written policies and procedures on medication self-administration.

2. The facility shall assist clients in the self-administration of prescriptions and non-prescription medication according to the client's service plan and as allowed by state laws and regulations.

3. Assistance with self-administration of medication shall be limited to the following:

a. the client may be reminded to take his/her medication;

b. the medication regimen, as indicated on the container, may be read to the client;

c. the dosage may be checked according to the container label;

d. staff may open the medicine container (i.e. bottle, mediset, blister pack, etc.) if the client lacks the ability to open the container; and

e. the client may be physically assisted in pouring or otherwise taking medications, so long as the client is cognitive of what the medication is, what it is for, and the need for the medication.

4. An employee that provides assistance with the self-administration of medications to a client shall have documented training on the policies and procedures for medication assistance including the limitations of this assistance. Documentation shall include the signature of the employee. This training shall be repeated at least annually.

5. Medications shall be stored in a secure central location and not stored in the client's own room.

6. The facility may require the clients to come to a "medication" area to take their medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### **Subchapter J. Secure Forensic Facility Module**

#### **§7285. General Provisions**

A. Providers applying for the Secure Forensic (SF) Facility module under the FSTRA facility license shall meet the core licensing requirement as well as the following module specific requirements.

B. A secure forensic facility is a secure residential facility located on the grounds of a state hospital that provides individualized services, including personal care services and medication administration, to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit, in order to prepare such persons for transition to a less restrictive environment before transitioning to the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

#### **§7287. Operational Requirements**

A. The SF facility shall provide 24-hour, seven day per week "supervision" consisting of at least three direct care staff persons during the day and two awake staff during the night. There shall be at least two direct care staff persons in each building and/or unit at all times when clients are present.

1. The SF facility shall have an RN on duty during the day shift to oversee the nursing services of the facility.

2. The SF facility shall have at least one licensed nurse on duty for each shift.

3. The SF Facility shall provide for, either directly or through contract, a medical doctor on call.

**B. Admission**

1. The SF facility shall:

a. admit clients who are under a court order or court ordered forensic conditional release and who are referred by a DHH state forensic facility;

b. not admit more clients into care than the number specified on the FSTRA facility's license; and

c. provide contact information, including the phone number and mailing address, for the appropriate state protection and advocacy organization.

**C. Client Services**

1. The facility shall provide or coordinate, to the extent needed or desired by clients, the following services:

a. assistance with activities of daily living and all instrumental activities of daily living;

b. medication administration;

c. opportunities for individual and group socialization;

d. services for clients who have behavior problems requiring ongoing staff support, intervention, and supervision to ensure no danger or infringement of the rights of other clients or individuals;

e. household services essential for the health and comfort of clients (e.g. floor cleaning, dusting, bed making, etc.);

g. basic personal laundry services; and

h. a program of recreational activities.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 28:31-28:37.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

**Family Impact Statement**

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 by ensuring continued access to services in a setting that protects the public as well as provides a controlled environment for individuals who are not capable of living independently and need structure in order to function adequately.

**Public Comments**

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule.

**Public Hearing**

A public hearing on this proposed Rule is scheduled for Thursday, February 24, 2011 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Bruce D. Greenstein  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Forensic Supervised Transitional  
Residential and Aftercare Facilities  
Minimum Licensing Standards**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO  
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

It is anticipated that implementation of this proposed rule will not have a programmatic fiscal impact to the state other than the cost of promulgation for FY 10-11. It is anticipated that \$8,200 (SGF) will be expended in FY 10-11 for the state's administrative expense for promulgation of this proposed rule and the final rule.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE  
OR LOCAL GOVERNMENTAL UNITS (Summary)**

It is anticipated that the implementation of this proposed rule will increase revenue collections to the Department by approximately \$250 for FY 10-11, \$250 for FY 11-12, and \$250 for FY 12-13 as a result of the collection of annual fees from the licensing of a forensic supervised transitional residential and aftercare facility (FSTRA).

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO  
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL  
GROUPS (Summary)**

This proposed rule, which continues the provisions of the September 20, 2010 emergency rule, adopts provisions governing the minimum licensing standards for forensic supervised transitional residential and aftercare facilities (3 facilities—1 private and 2 state facilities). It is anticipated that implementation of this proposed rule will have economic costs to the private FSTRA facility of approximately \$250 annually, and will benefit all FSTRA facilities by providing the licensure requirements for operation in the state of Louisiana.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT  
(Summary)**

This rule has no known effect on competition and employment.

Don Gregory  
Medicaid Director  
1101#082

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Department of Health and Hospitals  
Bureau of Health Services Financing**

Mental Health Rehabilitation Program  
Provider Participation Requirements  
(LAC 50:XV.703)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XV.703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the Mental Health Rehabilitation (MHR) Program to clarify staffing requirements, medical necessity criteria, provider participation requirements and provider responsibilities, and to remove the application fee

requirement for prospective MHR providers (*Louisiana Register*, Volume 34, Number 9).

The department now proposes to amend the provisions governing the provider participation requirements for the MHR Program to revise the application process for certification and enrollment in the program.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XV. Services for Special Populations**

##### **Subpart 1. Mental Health Rehabilitation**

#### **Chapter 7. Provider Participation Requirements**

##### **Subchapter A. Certification and Enrollment**

#### **§703. Application**

A. - B. ...

C. An applicant shall submit the following documents for certification:

1. MHR initial certification application;
2. proof of a request for accreditation and a copy of the completed application with a national accrediting body approved by the bureau and proof of payment to the accrediting body. Proof of full accreditation is required within nine months of issuance of a Medicaid provider enrollment number;
3. an affidavit that identifies the applicant's licensed mental health professional and psychiatrist, including verification of current licensure. The LMHP identified must be an employee of the applicant;
4. proof of the establishment and maintenance of a line of credit from a federally insured, licensed lending institution in an amount equal to three months of current operating expenses as proof of adequate finances. A budget showing actual or projected monthly expenses shall be attached. It is the MHR provider's responsibility to notify the bureau in the event that the financial institution cancels or reduces the upper credit limit;
  - a. nonprofit agencies that have operated for five years or more and have an unqualified audit report for the most recent fiscal year prepared by a licensed certified public accountant, which reflects financial soundness of the nonprofit provider, are not required to meet this standard;
  - b. governmental entities or organizations are exempt from this requirement;
5. a statement identifying the population to be served:
  - a. adults with serious mental illness; or
  - b. children with an emotional/behavior disorder;
6. proof of the establishment and maintenance of a general liability and a professional liability insurance policy with at least \$1,000,000 coverage under each policy. The certificates of insurance for these policies shall be in the name of the MHR provider and certificate holder shall be the Department of Health and Hospitals. The provider shall notify the bureau when coverage is terminated for any reason. Coverage shall be maintained continuously throughout the time services are provided and thereafter for a period of one year;
  - a. governmental entities or organizations are exempt from this requirement;
7. identification of all the MHR provider's office locations and off-site service delivery locations;
8. proof that all owner and staff have attended mandatory training as required by the bureau;

9. proof that all equipment and technology requirements have been met as established by the bureau;

10. corporations must provide current proof of business registration with the Secretary of State;

11. proof of clinical competence as defined and required by the bureau;

12. a notarized report of any and all settled convictions and/or pending charges of malpractice and felonies for the business itself (in this or any other name), the owners, principals, partners and/or governing bodies, Board of Directors and the executive/managing director;

13. proof of current inspection and approval by the Office of State Fire Marshal;

14. proof of current inspection and approval by the Office of Public Health; and

15. a comprehensive administrative policy and procedure manual that describes an administrative structure to provide MHR services as defined and required by the bureau.

D. An applicant shall submit the following documents to the bureau's designated Provider Enrollment Unit for Medicaid Enrollment:

1. a Medicaid basic enrollment packet for entities/businesses;
2. an enrollment packet for the Louisiana Medical Assistance Program-Mental Health Rehabilitation;
3. an enrollment packet for the Louisiana Medical Assistance Program-Physician, individual or group, if applicable; and
4. a certification approval letter from the Medicaid Behavioral Health Section which states that all certification requirements have been met.

E. The MHR provider shall obtain a separate Medicaid provider number for each location where it routinely conducts business and provides scheduled services. This does not include those sites or locations that meet the definition of an off-site service delivery location.

F. Optional Services Certification. An applicant who elects to offer one or more optional services shall apply to the Bureau of Health Services Financing or its designee. The applicant shall create and maintain documents to substantiate that the provider meets all prerequisites for certification.

1. An applicant shall submit the following documents for certification:

- a. MHR Optional Services Certification application;
- b. comprehensive implementation plan;
- c. proof of current inspection and approval of the site for psychosocial rehabilitation (PSR), by the Office of State Fire Marshal;
- d. proof of current inspection and approval of the site for PSR, by the Office of Public Health; and
- e. proof that the supervising LMHP for PSR is a Certified Psychosocial Rehabilitation Practitioner (CPRP). If the LMHP is not a CPRP, submit a written plan for achieving certification within 12 months of the provider's certification or within 12 months of being hired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1086 (May 2005), amended LR 32:2069

(November 2006), LR 34:1914 (September 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:

### Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

### Public Comments

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. He is responsible for responding to inquiries regarding this proposed Rule.

### Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, February 24, 2011 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Bruce D. Greenstein  
Secretary

## FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

### RULE TITLE: Mental Health Rehabilitation Program; Provider Participation Requirements

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 10-11. It is anticipated that \$574 (\$287 SGF and \$287 FED) will be expended in FY 10-11 for the state's administrative expense for promulgation of this proposed rule and the final rule.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 10-11. It is anticipated that \$287 will be collected in FY 10-11 for the federal share of the expense for promulgation of this proposed rule and the final rule.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule proposes to amend the provisions governing the provider participation requirements for the MHR Program to revise the application process for certification and enrollment in the program. This procedural change is needed to facilitate smoother processing of provider applications by having individual forms sent directly to the entity that will process them. It is anticipated that implementation of this proposed rule will have no effect on persons or non-governmental groups in FY 10-11, FY 11-12 and FY 12-13.

#### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Don Gregory  
Medicaid Director  
1101#083

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

## NOTICE OF INTENT

### Department of Health and Hospitals Bureau of Health Services Financing

#### Nursing Facilities—Per Diem Rate Reduction (LAC 50:VII.1305)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:VII.1305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

As a result of a continuing budgetary shortfall in state fiscal year 2010, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem rate paid to non-state nursing facilities (*Louisiana Register*, Volume 36, Number 2). The final Rule was published November 20, 2010 (*Louisiana Register*, Volume 36, Number 11). In anticipation of projected expenditures in the Medical Vendor Program exceeding the funding allocated in the General Appropriations Act for state fiscal year (SFY) 2010, the department reduced the per diem rates paid to non-state nursing facilities (*Louisiana Register*, Volume 36, Number 7). In anticipation of projected expenditures exceeding the funding allocated in the General Appropriations Act for SFY 2011, the department promulgated an Emergency Rule which further reduced the per diem rates paid to non-state nursing facilities (*Louisiana Register*, Volume 36, Number 7). In compliance with Act 244 of the 2009 Regular Session of the Louisiana Legislature, the department amended the provisions governing the reimbursement methodology for nursing facilities to adjust the periodic rebasing of the nursing facility rates (*Louisiana Register*, Volume 36, Number 8). The department amended the provisions of the July 1, 2010 Emergency Rule governing the SFY 2011 rate reduction to revise the formatting of LAC 50:VII.1305 as a result of the promulgation of the July 20, 2010 and the August 20, 2010 final Rules (*Louisiana Register*, Volume 36, Number 10).

As a result of Act 244, the nursing facility rates were rebased on July 1, 2010. For SFY 2011-2012, state general fund will be required to continue nursing facility rates at the rebased level. Because of the fiscal crisis facing the state, the state general funds will not be available to sustain the increased rates. Consequently, the department proposes to amend the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem

rates paid to non-state nursing facilities. The effect of the reductions will remove the rebased amount and sunset the 2010-2011 nursing facility rebasing.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part VII. Long Term Care Services**

**Subpart 1. Nursing Facilities**

**Chapter 13. Reimbursement**

**§1305. Rate Determination**

A. - F. ...

G. Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 until such time as the rate is rebased.

H. Effective for dates of service on or after July 1, 2011, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by \$26.98 of the rate in effect on June 30, 2011 until such time that the rate is rebased.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

**Family Impact Statement**

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule may have an adverse impact on family functioning, stability and autonomy as described in R.S. 49:972 in the event that provider participation in the Medicaid Program is diminished as a result of reduced reimbursement rates.

**Public Comments**

Interested persons may submit written comments to Don Gregory, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule.

**Public Hearing**

A public hearing on this proposed Rule is scheduled for Thursday, February 24, 2011 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Bruce D. Greenstein  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Nursing Facilities  
Per Diem Rate Reduction**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

It is anticipated that the implementation of this proposed rule will result in estimated programmatic savings to the state of \$52,728,535 for FY 11-12 only. There are no ongoing savings due to the rates being rebased again on July 1, 2012. It is anticipated that \$410 (\$205 SGF and \$205 FED) will be expended in FY 10-11 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 74.76 percent (in FY 10-11). The enhanced rate of 81.48 percent for the first six months of the fiscal year is authorized by the American Recovery and Reinvestment Act (ARRA) of 2009. To the extent that additional enhanced federal match would be available and appropriated after December 2010 (end of the ARRA eligibility), state general fund match could be reduced in the current fiscal year.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by approximately \$109,263,891 for FY 11-12 only. There are no ongoing revenue collections due to the rates being rebased again on July 1, 2012. It is anticipated that \$205 will be expended in FY 10-11 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 74.76 percent (in FY 10-11). The enhanced rate of 81.48 percent for the first six months of the fiscal year is authorized by the American Recovery and Reinvestment Act (ARRA) of 2009. To the extent that additional enhanced federal match would be available and appropriated after December 2010 (end of the ARRA eligibility), state general fund match could be reduced in the current fiscal year.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

This proposed rule amends the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem rates paid to non-state nursing facilities as a means of removing the FY 11 increase as a result of the July 1, 2010 nursing facility rebasing (approximately 6,550,000 nursing home days per year). It is anticipated that implementation of this proposed rule will reduce program expenditures in the Medicaid Program by approximately \$161,992,426 for FY 11-12 only.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

It is anticipated that the implementation of this proposed rule will not have an effect on competition. However, we anticipate that the implementation may have a negative effect on employment as it will reduce the payments made to nursing facilities. The reduction in payments may adversely impact the financial standing of nursing facilities and could possibly cause a reduction in employment opportunities.

Don Gregory  
Medicaid Director  
1101#084

H. Gordon Monk  
Legislative Fiscal Officer  
Legislative Fiscal Office

## NOTICE OF INTENT

### Department of Public Safety and Corrections Corrections Services

#### Disaster Remediation Program (LAC 22:I.340)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, hereby gives notice of its intent to change the title and amend the contents of LAC 22:I.340, Community Resource Centers.

#### Title 22

### CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

#### Part I. Corrections

#### Chapter 3. Adult Services

#### §340. Disaster Remediation Program.

A. Purpose—to state the secretary's policy regarding a disaster remediation program for eligible offenders to participate in emergency disaster relief efforts and to provide procedures regarding housing for those offenders who participate in such relief efforts.

B. Applicability—deputy secretary, undersecretary, assistant secretary, chief of operations, regional wardens, wardens, Director of Probation and Parole and Director of Prison Enterprises. Each unit head is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation.

C. Policy—it is the secretary's policy to establish a disaster remediation program for offenders to repair the damage done following a natural disaster or emergency. The use of offender labor shall augment governmental personnel, private sector firms and community volunteers conducting remediation activities during the period immediately after such disaster. Offender labor shall not replace existing employees, be utilized on a project or job involved in a labor dispute or supplant post disaster remediation activities that may otherwise be performed under contract by private sector firms employed by an affected individual or governmental entity.

#### D. Definitions

1. *Advance Support Team*—advance support teams secure appropriate housing, coordinate the delivery of necessary supplies, and address and/or assess current situations and conditions, as well as assess future needs. The team shall consist of a security supervisor and maintenance staff member. Other staff and/or offenders may be included as deemed necessary by the chief of operations, regional wardens and/or the warden.

2. *Minimum Custody*—general population dormitory housing area. Movement outside of a secure perimeter is usually authorized without armed supervision or restraint. Institutional procedure governs the level of staff supervision when outside the secure perimeter, as well as internal movement controls.

3. *Offender Crews*—offender crews may be composed of any offenders that are classified as minimum custody at their assigned housing unit, excluding offenders prohibited from participation as provided for in Subsection E. Eligible offenders are subject to placement on the crews regardless of their usual work assignment. Additionally, offenders are

required to be on a regular duty status and be medically capable of performing emergency disaster relief work.

E. Statutory Ineligibility for Participation. Offenders shall not be eligible to participate in a disaster remediation program if the offender was convicted of a crime defined or enumerated as a crime of violence in R.S. 14:2(13) or the offender was convicted of a sex offense as defined in R.S. 15:541(24).

#### F. Pre-Deployment

1. Each warden shall determine the approximate number of offenders available for assignment to an offender crew and develop appropriate offender and staffing rosters. Information concerning the number of crews available from each facility shall be forwarded by the warden or designee each May to the chief of operations for inclusion in the Incident Management Center (IMC) Resource Manual.

2. Offender crews shall not exceed ten offenders for each correctional officer supervising them.

3. In accordance with the Louisiana Homeland Security and Emergency Assistance and Disaster Act, after the governor has declared a disaster or emergency pursuant to executive order or proclamation, a disaster remediation program may be established in the parish where the work will be performed.

4. At the direction of the secretary or designee, the IMC shall contact the appropriate warden with information relative to disaster relief needs of the affected area and/or the necessity of establishing a disaster remediation program.

5. Upon receiving the instructions from the IMC, the warden shall activate the advance support team, other necessary personnel and offender crews.

6. Offender crews that are deployed to a community or area more than two hours travel time from the unit or for an extended period may require housing in that area. The advance support teams shall coordinate with the parish Office of Emergency Preparedness (OEP), local law enforcement and the district probation and parole office for accessing available housing resources.

#### G. Deployment

1. The rank structure for supervision of a disaster remediation effort shall be determined by the appropriate regional warden and the unit warden shall ensure that logs of offender crew activities are maintained.

2. The unit warden shall be responsible for providing transportation for each offender crew. In addition, each unit shall be responsible for providing their own communications equipment such as 700 radios, cell and/or satellite telephones and an EMT or nurse to provide emergency medical care to the offender crews in the area as may be required.

3. The unit warden shall ensure that supervising staff receives documentation for each offender crew member that includes an identification picture and master prison record. In addition, supervising staff shall receive any medications that the offenders may have been prescribed.

4. Offender crew remediation assignments shall be coordinated by unit personnel on site through the state and/or local OEP. This information shall be forwarded to the unit, the IMC and local law enforcement.

5. The IMC may coordinate with the Division of Probation and Parole for any additional security support needed at a disaster remediation site.

**NOTICE OF INTENT**

**Department of Public Safety and Corrections  
Corrections Services**

**Supervised Release of Sex Offenders upon Expiration of  
Sentence (LAC 22:I.403)**

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, hereby gives notice of its intent to amend the contents of LAC 22:I.403, Supervised Release of Sex Offenders upon Expiration of Sentence.

**Title 22**

**CORRECTIONS, CRIMINAL JUSTICE AND LAW  
ENFORCEMENT**

**Part I. Corrections**

**Chapter 4. Division of Probation and Parole**

**§403. Supervised Release of Sex Offenders upon  
Expiration of Sentence.**

A. Purpose—to state the secretary’s policy regarding the supervised release of sex offenders upon expiration of sentence pursuant to legislative intent.

B. Applicability—deputy secretary, assistant secretary and the Director of Probation and Parole. The Director of Probation and Parole is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation and to convey its contents to appropriate staff and any and all affected sex offenders under supervision pursuant to this regulation.

C. Policy—it is the secretary’s policy that a uniform procedure be established and adhered to relative to the supervised release of certain sex offenders who have been released from the custody of the department upon expiration of sentence.

**D. Definition**

*Probation and Parole Officer*—for the purpose of this regulation, shall include supervised release officers, Department of Public Safety and Corrections officers and supervising officers as these terms are utilized in R.S. 15:561.1 through 7. Probation and parole officers are employed by the Division of Probation and Parole and have all the powers and duties of probation and parole officers as provided by law.

**E. General Procedures**

1. A person convicted on or after August 15, 2006, and releasing on or after August 15, 2008, of a sex offense as defined in R.S. 15:541 when the victim is under the age of thirteen years, as stated on the bill of information, shall be placed upon supervised release for life when he is released from the custody of the Department of Public Safety and Corrections upon expiration of his sentence. Notwithstanding any other provision of law to the contrary, any person who is placed upon supervised release may petition the sentencing court for a termination of the supervision.

2. Supervised release shall be administered by the Division of Probation and Parole.

6. If the situation or conditions dictate, a centralized supply location or warehouse may be established to support offender work crews.

H. Good Time Credit. Offenders participating in the disaster remediation program shall be eligible to earn 30 days of good time credit in addition to that otherwise authorized by law for every thirty days of service in this program. Therefore, each unit shall maintain records of the offenders assigned to the work crews and the number of days worked. These records shall be forwarded to the records office at the facility to determine the amount of good time to be awarded to the offender.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:833.1.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 33:665 (April 2007), amended LR 37:

**Family Impact Statement**

Amendment to the current Rule has no known impact on family formation, stability or autonomy, as described in R.S. 49:972.

**Public Comments**

Written comments may be addressed to Melissa Callahan, Deputy Assistant Secretary, Department of Public Safety and Corrections, P. O. Box 94304, Baton Rouge, LA 70804 until 4:30 p.m. on February 8, 2011.

James M. Le Blanc  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Disaster Remediation Program**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO  
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The proposed rule change will have no impact on state or local government expenditures. This is a technical adjustment to an existing regulation regarding the name change from community resource programs to a disaster remediation program in which offender labor repairs damage caused by a natural disaster or emergency.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE  
OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no impact on the Revenue Collections of state or local governmental units as a result of this technical adjustment.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO  
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL  
GROUPS (Summary)**

There is no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT  
(Summary)**

There is no estimated effect on competition and employment as a result of this technical adjustment.

Thomas Bickham, III  
Undersecretary  
1101#053

Robert E. Hosse  
Staff Director  
Legislative Fiscal Office

3. When a sex offender is placed on supervised release pursuant to the provisions of this regulation, the probation and parole officer shall:

- a. inform the sex offender that he will be placed upon supervised release for the duration of his natural life;
- b. inform the sex offender of the conditions of supervised release as provided for in R.S. 15:561.5 (see Subsection F of this Section);
- c. require the sex offender to read and sign a Notification of Supervised Release Certificate to verify the fact that the sex offender will be placed upon supervised release and that the conditions of the supervised release have been explained to him.

F. Supervised Release Conditions

1. A sex offender placed on supervised release pursuant to the provisions of this regulation shall comply with the following conditions:

- a. report immediately to the Division of Probation and Parole district office which is listed on the certificate of supervised release;
- b. establish a schedule of a minimum of one meeting per month with the probation and parole officer to provide the officer with his current address, e-mail address or addresses, instant message name or names, date of birth, place of employment and verification of compliance with all registration and notification requirements of a sex offender as required by statute;
- c. be subject to periodic visits with the probation and parole officer without prior notice;
- d. abide by any curfew set by the probation and parole officer;
- e. refrain from using or possessing any controlled dangerous substance or alcoholic beverage and submit, at the sex offender's expense, to screening, evaluation and treatment for controlled dangerous substances or alcohol abuse as directed by the probation and parole officer;
- f. refrain from using or possessing any pornographic or sexually explicit materials. "Pornographic or sexually explicit materials" means any paper, magazine, book, newspaper, periodical, pamphlet, composition, publication, photograph, drawing, phonograph record, album, cassette, wire or tape recording, compact disc, digital versatile disc, digital video disc or any other form of visual technology or other similar tangible work or thing which is devoted to or principally consists of descriptions or depictions of illicit sex or sexual immorality, the graphic depiction of sex, including but not limited to the visual depiction of sexual activity or nudity, ultimate sexual acts, normal or perverted, actual, simulated or animated, whether between human beings, animals or an animal and a human being;
- g. report to the probation and parole officer when directed to do so;
- h. not associate with persons known to be engaged in criminal activities or with persons known to have been convicted of a felony without written permission of the probation and parole officer;
- i. in all respects, conduct himself honorably, work diligently at a lawful occupation and support his dependents, if any, to the best of his ability;

j. promptly and truthfully answer all inquiries directed to him by the probation and parole officer;

k. live and remain at liberty and refrain from engaging in any type of criminal conduct;

l. not have in his possession or control any firearms or dangerous weapons;

m. submit himself to available medical, psychiatric or mental health examination and treatment for offenders convicted of sex offenses when deemed appropriate and ordered to do so by the probation and parole officer;

n. defray the cost, or any portion thereof, of the supervised release by making payments to the department in a sum and manner determined by the department, based upon the offender's ability to pay;

o. submit a residence plan for approval by the probation and parole officer;

p. submit himself to continued supervision, either in person or through remote monitoring, of all of the following internet related activities:

i. the sex offender's incoming and outgoing e-mail and other internet-based communications;

ii. the sex offender's history of websites visited and the content accessed; and

iii. the periodic unannounced inspection of the contents of the sex offender's computer or any other computerized device or portable media device and the removal of such information, computer, computer device or portable media device to conduct a more thorough inspection;

q. comply with such other specific conditions as are appropriate, stated directly and without ambiguity so as to be understandable to a reasonable man.

2. Sex offenders on supervised release pursuant to this regulation shall be subject to the same probation and parole policies and procedures as any other sex offender on probation or parole supervision.

G. Sanctions for Failure to Comply

1. Sex offenders on supervised release who fail to comply with the conditions of their release and supervision as provided for in Subsection F shall be referred to the district attorney for prosecution of the new charge pursuant to R.S. 15:561.7.

2. Upon a first conviction of R.S. 15:561.7, the sex offender shall be fined not more than one thousand dollars and imprisoned with hard labor for not less than 2 years nor more than 10 years without benefit of parole, probation or suspension of sentence.

3. Upon a second or subsequent conviction of R.S. 15:561.7, the sex offender shall be fined three thousand dollars and imprisoned with hard labor for not less than 5 years or more than 20 years without benefit of parole, probation or suspension of sentence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:950.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 34:1424 (July 2008), amended LR 35:253 (February 2009), LR 37:

**Family Impact Statement**

Amendment to the current Rule has no known impact on family formation, stability or autonomy, as described in R.S. 49:972.

**Public Comments**

Written comments may be addressed to Melissa Callahan, Deputy Assistant Secretary, Department of Public Safety and Corrections, P. O. Box 94304, Baton Rouge, LA 70804 until 4:30 p.m. on February 8, 2011.

James M. Le Blanc  
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE:Supervised Release of Sex Offenders  
upon Expiration of Sentence**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The proposed rule change will result in an indeterminable increase in state government expenditures. The estimated cumulative cost to the state for implementation of the Supervised Release of Sex Offenders Upon Expiration of Sentence is a combination of a mandatory one-time cost, supervision for the remainder of an offender’s natural life, and collections of parole fees as self-generated revenue. The rule change is a result of Act 672 of the 2008 Regular Session and Act 205 of the 2009 Regular Session.

The state cost to monitor an offender placed under GPS supervision would be \$2,029.40 in the first year of supervision and \$1,182.60 each year after. The increased cost in year 1 is due to a one-time residency plan cost of \$846. The cost of GPS supervision is \$3.24 per day per offender. The offender would be required to pay the parole supervision fee of \$50 per month.

The changes proposed would affect only those offenders convicted between the dates of on or after August 15, 2006 and released on or before August 15, 2008, whose victims were under the age of 13. According to Department statistics, this involves a total of 227 offenders, with an average age at conviction of 44 years and an average imposed sentence length of 19.49 years. The Department of Corrections estimates that an average of 5 offenders released each year would be subject to GPS supervision.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

Parole fees would be collected at \$50 per month per offender, or \$600 annually per offender each year. Self-generated revenues are based on supervision fees being collected from the portion of the 227 offenders that would be subject to such stipulations upon expiration of sentence.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

There is an indeterminable amount of estimated costs and/or economic benefits to directly affected persons or non-governmental groups. However, the proposed plan will protect the public safety by establishing a uniform procedure relative to the supervised release of sex offenders who have been released from custody of the Department upon expiration of sentence.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)**

There is no estimated effect on competition and employment.

Thomas C. Bickham, III  
Undersecretary  
1101#054

Robert E. Hosse  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Office of Public Safety and Corrections  
Gaming Control Board**

**Casino Gaming Payment Interception (LAC 42:III.2737)**

The Louisiana Gaming Control Board hereby gives notice that it intends to promulgate LAC 42:III.2737. This Rule, required by R.S. 27:24(A)(5)(f), will intercept casino winnings from casino patrons who either received child support overpayments or are in arrears in satisfying court ordered child support payments and remit them to the Louisiana Department of Children and Family Services.

**Title 42**

**LOUISIANA GAMING**

**Part III. Gaming Control Board**

**Chapter 27. Accounting Regulations**

**§2737. Casino Gaming Payment Interception**

A. The Department of Children and Family Services (DCFS) shall provide real-time or immediate electronic access to a database containing current information for persons having child support arrearages or overpayments. This access shall be available to the entities licensed or permitted under Chapters 1, 4, 5, or 7 of R.S. 27 et seq.

B.1. Prior to issuing payment of winnings (either cash or a second or later progressive slot machine annuity payment) in an amount requiring the filing of a W-2G or substantially equivalent form, the payor shall access the DCFS database to determine if the winning patron is recorded as owing overdue child support or receiving child support overpayments.

2. If the patron is recorded by DCFS as owing overdue child support or as having received overpayments, the payor may deduct up to \$35 as an administrative fee and shall then intercept the amount noted in the DCFS database from the patron’s winnings. Any amount remaining following the deduction of the administrative fee, intercept amount, and any other deductions required by law shall then be paid to the winning patron.

3. If the winning patron’s information is not recorded in the DCFS database, a licensee shall maintain a record of the negative search results for each payment made to a cash prize winner by attaching a print out of a negative results, or similar "No Record Found," page generated by the DCFS database to the jackpot payout slip. A DCFS generated log of all searches made may be printed and maintained in the licensee’s accounting records in lieu of attaching a negative results record to each jackpot payout slip.

4. If the winning patron’s information is not recorded in the DCFS database, a permittee who issues a second or later progressive slot annuity payment shall maintain a copy of the negative results or other “No Record Found” page generated by the DCFS database for each payment made to a progressive slot jackpot annuitant.

C.1. Intercepted amounts shall be forwarded to DCFS within seven business days in accordance with R.S. 27:24(A)(5)(c) and shall include a record of the identifying information for the individual from whom the payment was intercepted and the amount intercepted from each individual.

2. Licensees may aggregate multiple interception amounts for transfer to DCFS provided they provide a simultaneous record of the identifying information for the individuals from whom the payment was intercepted and the amount intercepted from each individual.

D.1. Licensee's internal controls shall include, but not be limited to, the following:

a. the amount of the administrative fee charged for processing DCFS interceptions;

b. either a list of employees authorized to access the DCFS database or an authorization noted in an authorized employee's job description;

c. procedures designed to prevent employees from willfully failing to withhold intercept payments from persons who have outstanding child support arrearages or child support overpayments;

d. procedures for restricting access to any DCFS database to authorized employees in such a manner that identifies the employee accessing the database;

e. procedures for ensuring only authorized employees access the database;

f. procedures for accessing and searching the DCFS database;

g. procedures for preserving the confidentiality of the information retrieved from the DCFS database;

h. procedures for ensuring the amount paid to a winning patron shall equal the jackpot or cash prize less the administrative fee, the interception amount, and tax withholdings if any;

i. procedures for preventing patrons with outstanding child support arrearages or overpayments to transfer or assign their jackpots to another patron;

j. procedures for withholding payment from patrons listed in the database;

k. procedures for notifying patrons subject to interception of the withholding by providing them with a receipt stating the reason for the interception, the amount withheld, and contact numbers for DCFS;

l. procedures for attaching a copy of the winning patron's interception receipt to the jackpot slip maintained by the cashier;

m. procedures for attaching the documentation required by Subsection F to the jackpot slip in the event the DCFS database is inaccessible; and

n. procedures for the timely forwarding intercepted payments to DCFS.

E. Any licensee or permittee who issues a second or later progressive slot machine annuity payment shall include in its internal controls, the procedures required in this section for jackpot intercepts.

F. Any licensee or permittee searching the database or withholding money in accordance with R.S. 27:24(A) and this Section, shall submit a monthly report to the division by the twentieth day of the month detailing the total number of searches of the DCFS database, the number of matches found, the amount of jackpot winnings withheld, and the amount of administrative fees retained for the preceding month.

G. In the event the DCFS database is off-line when a search is made, a licensee shall not be responsible for intercepting cash winnings provided it prints a copy of the screen notification that the system is inaccessible, records

the name and prize amount for the winning patron, and timely notifies DCFS of the error to ensure the technical difficulty is not with the licensee. The unavailability of the DCFS database shall not affect interception requirements for second or later progressive slot machine annuity payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Louisiana Gaming Control Board, LR 37:

#### **Family Impact Statement**

Pursuant to the provisions of R.S. 49:953(A), the Louisiana Gaming Control Board, through its chairman, has considered the potential family impact of adopting LAC 42:III.2737.

It is accordingly concluded that adopting LAC 42:III.2737 would likely have a positive yet inestimable impact on family earnings and family budget but not affect the following:

1. stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. the behavior and personal responsibility of children.

#### **Small Business**

Pursuant to the provisions of R.S. 49:965.5 the Louisiana Gaming Control Board, through its chairman, has concluded that there will be no adverse impact on small business if LAC 42:III.2737 is adopted as it does not apply to small businesses.

#### **Public Comments**

All interested persons may contact Jonathon Wagner, Attorney General's Gaming Division, telephone (225) 326-6500, and may submit comments relative to these proposed Rule, through February 10, 2011, to 1885 North Third Street, Suite 500, Baton Rouge, LA 70802.

Dane K. Morgan  
Chairman

### **FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

#### **RULE TITLE: Casino Gaming Payment Interception**

#### **I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed administrative rule changes will have no implementation costs to state or local governmental units. The Gaming Control Board is proposing rules and procedures that require casinos to intercept and deduct winnings from patrons identified in the Department of Children and Family Services' database as individuals who have either received child support overpayments or are in arrears in making child support payments.

#### **II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)**

The proposed changes will not create any foreseeable impact on revenue collections for either the state or local governmental units.

#### **III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)**

Casinos may deduct up to \$35 from a patron's winnings as an administrative fee for intercepting and forwarding the deductions identified in the Department of Children and Family Services database.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed administrative rule changes will have no effect on competition and employment.

Dane K. Morgan  
Chairman  
1101#063

Evan Brasseaux  
Staff Director  
Legislative Fiscal Officer

**NOTICE OF INTENT**

**Department of Public Safety and Corrections  
Office of the State Fire Marshal**

Property Protection Licensing (LAC 55:V.Chapter 32)

In accordance with the provisions of R.S. 49:950 et seq. and R.S. 40:1484.3, relative to the authority of the state fire marshal to promulgate and enforce rules, relative to the regulation of Life Safety and Property Protection, in particular, Security, Household Fire Warning, Locksmiths, Stand Alone Electro/Mechanical, Door Hardware, Door Hardware Consultation, Bank Locking, Detention Locking, Gate Systems, Special Locking and Closed Circuit Television Equipment and/or Systems, notice is hereby given that the Office of the State Fire Marshal intends to adopt the following rules.

**Title 55**

**PUBLIC SAFETY**

**Part V. Fire Protection**

**Chapter 32. Property Protection Licensing**

**§3201. Purpose**

A. The purpose of these rules is to regulate the activity of certifying, designing, inspecting, installing, integrating, maintaining, selling and servicing of security, household fire warning, stand alone electro/mechanical locking, door hardware, door hardware consultation, bank locking, bank auxiliary, detention locking, gate systems, special locking and closed circuit television equipment and/or systems in the interest of protecting and preserving lives and property pursuant to authority of R.S. 40:1664.1 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3203. Applicability of Rules**

A. These rules shall apply to all firms and persons engaged in property protection activity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3205. Exceptions**

A. These rules shall not apply to the following:

1. firms and/or persons engaging in the activity of certifying, inspecting, installing, integrating, or servicing fire detection and alarm equipment and/or systems in commercial businesses;

2. the certifying, inspecting, installing, integrating, or servicing of security or CCTV equipment and/or systems by building owners or their direct employees;

3. public agencies and their direct employees engaging in the activity of certifying, inspecting, installing, integrating, or servicing camera systems in public vehicles;

4. law enforcement agencies or private investigation firms currently licensed by the Louisiana Board of Private Investigators installing camera systems in conjunction with an active investigation. Individual private investigators must be licensed through a private investigation firm with the Louisiana Board of Private Investigators to be exempt from this Subpart;

5. firms and/or persons who sell security, locking and/or camera systems and equipment at wholesale to contractors licensed per R.S. 40:1664.1 et seq.;

6. general contractors and their employees who are properly licensed through the Louisiana State Board of Contractors or a building owner that installs or removes complete stand alone electro-mechanical locks when doing so in the course of residential or commercial new construction or remodeling. Additionally, the general contractor can install all associated hardware specified to be installed on the door. This exemption only applies to the firm which is acting as the general contractor on the project. It does not apply to other firms which hold a General contractor's license but are only acting as a sub-contractor on the project;

7. any merchant or retail store that is in the business of recoding new locks on the retail premises. Locks must be purchased at the same location and recoded at the time of purchase;

8. firms and/or persons who only install bank locking equipment, including but not limited to, vaults, safes, automatic teller machines, and/or safety deposit boxes, while doing so in conjunction with a licensed locksmith or bank locking contractor. The licensed locksmith or bank locking contractor shall certify the installation;

9. any manufacturer, and his employee or representative, who acts as a consultant to a certified firm in the certifying, inspecting, installing, integrating, or servicing of property protection systems and/or equipment while under the direct supervision of the certified firm.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3207. Notices by the Fire Marshal**

A. Any notice required to be given by the state fire marshal by any provision of R.S. 40:1664.1 et seq., or these rules must be given by personal or domiciliary service or mailed, postage prepaid, to the person's residence or firm address as it appears on the records in the Office of State Fire Marshal. It is the responsibility of the person or firm involved to ensure that the Office of the State Fire Marshal has a correct address for the person or firm.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3209. Certificate, License Required**

A. Each firm engaged in property protection activity shall apply for a certificate of registration in the endorsements of certification desired in accordance with these rules prior to conducting any such activity in this state.

B. Each person or employee, including apprentices, engaged in property protection activity shall apply for a license in the endorsements of licensure desired in

accordance with these rules prior to conducting any such activity in this state.

C. Any firm and/or person described in A or B of this section, which has not applied for and received a current and valid certificate of registration or license, shall immediately cease such activities. The Office of State Fire Marshal shall take all steps necessary to enforce an order to cease and desist and pursue administrative penalties against violators of this Subpart.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 40:1664.2 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3211. Definitions**

A. The following words and terms, when used in these rules, shall have the following meanings, unless the context clearly indicates otherwise.

*Access Control Systems*—those locking systems and equipment as outlined in NFPA 101 designed to restrict entry into an area, room, building or space. These systems require an annual certification.

*Apprentice*—a person who is licensed to work under the direct supervision and accompaniment of a technician who is licensed to the same firm and holding a valid license to perform the same acts.

*Apprentice Endorsement*—that document issued by the state fire marshal to an employee to engage in property protection activity while under the direct supervision of a technician who is licensed to the same firm and holding a valid license to perform the same acts.

*Bank Auxiliary Systems*—systems and equipment which are found in financial institutions but are not directly associated with locking systems. Such systems, include but are not limited to, after hour depositories, tube systems, teller audio/video systems, and automatic teller machines, excluding the safe.

*Bank Auxiliary Systems Endorsement*—that document issued by the state fire marshal to an employee of a certified property protection firm to engage in property protection activity of bank auxiliary systems.

*Bank Locking Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of bank locking systems and equipment.

*Bank Locking Systems*—locking systems and equipment found in financial institutions or designed for protection of financial transactions in other commercial businesses. Such systems and equipment include, but is not limited to, vaults, safes, automatic teller machines, cash dispenser, safe deposit boxes, tube systems, closed circuit television and depository systems and/or equipment. The term includes stand alone electro/mechanical locks but does not include security or special locking systems.

*Certificate of Registration*—that document issued by the state fire marshal to a firm authorizing it to engage in such activities as defined in these rules.

*Certify*—to attest to the proper functionality, inspection, installation, integration, maintenance, or service of property protection equipment and systems in accordance with all applicable engineered specifications, manufacturer's specifications, the applicable NFPA codes and standards and the reviewed fire marshal plans.

*Closed Circuit Television Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of closed circuit television systems and equipment. This includes the connection of closed circuit television systems and equipment to computer systems or equipment.

*Closed Circuit Television System*—a system and its components which transmits video and/or audio signals or images via cameras, computer or other means. Transmissions may be done via hard wire, including, but not limited to, coaxial cable, fiber optic cable, network cable, internet protocol (IP), or wireless devices and means. The term includes security camera and/or surveillance camera systems.

*Commercial Businesses*—all buildings including, but not limited to, public, private and industrial structures. The term does not include one and two family dwellings.

*Contact Person*—that individual designated by a firm to act as liaison with the Office of the State Fire Marshal.

*Delayed Egress Systems*—those locking systems and equipment as outlined in NFPA 101 designed to impeded egress for a specified limited time from an area, room, building or space. These systems require an annual certification.

*Design*—to create a specific layout for a property protection system for the purpose of protecting persons and/or property. The term “layout of the system” only refers to those persons who physically create such layout after visiting the location. Design and/or layout of the system's devices shall follow manufacturer's recommendations and application limitations.

*Detention Locking Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of detention locks and locking systems and equipment as related to cell areas in penal institutions and cell areas in other occupancies such as health care or business.

*Detention Locking Systems*—locking systems and equipment within a penal institution and in other occupancies having such systems and equipment in cell areas only. The term includes locks of various types including pin tumbler-standard and mogul types, lever and wafer tumbler, stand alone electro/mechanical and full electronic and pneumatic controlled locks. The term does not include special locking systems within non-cell areas of the building. These systems require an annual certification.

*Direct Supervision*—oversight given by a qualifier of a firm's employees or by a technician of an apprentice while performing property protection activity. The qualifier, the technician and apprentice must be licensed to the same firm. A qualifier is considered to provide direct supervision of employees if he routinely engages and regularly reviews the daily property protection activity of the employees of the firm. For a technician to provide direct supervision of an apprentice, both must be physically present at the same work location. They are not required to constantly be in line of sight of each other.

*Door Hardware*—builders' hardware or architectural hardware, including but not limited to, stand alone electro/mechanical locks, latches, exit hardware, closures and hinges mounted onto doors intended to operate and

secure the door properly. The term does not include special locking systems and equipment, doors or door frames.

*Door Hardware Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of door hardware equipment and the consulting or the providing of technical advice regarding the selection of door hardware. The termination of these components to the building power system is not permitted. The term does not include special locking systems.

*Door Hardware Consultant Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in the consulting and/or the providing of technical advice regarding the selection of door hardware.

*Electronically Controlled Egress Door Assemblies*—those locking systems and equipment as outlined in NFPA 101 designed to restrict entry into an area, room, building or space. The release of such locking systems incorporates a mechanical switch that interrupts power to a magnetic or electric lock. These systems require an annual certification.

*Elevator Lobby Exit Access Door Assembly Locking Systems*—those locking systems and equipment as outlined in NFPA 101 designed to restrict entry into an area, room, building or space from an elevator lobby. The release of such locking systems incorporates redundant features. These systems require an annual certification.

*Employee*—a person who works for a "firm" as defined by R.S. 40:1664.2 et seq., in return for financial or other compensation.

a. For the purposes of the licensing requirements, contained in R.S. 40:1664.2 et seq., employees shall not include secretaries, drivers or accounting or other administrative personnel.

b. For the purposes of licensing requirements, the firm owner or owners shall be considered an "employee" if he or she is or will be certifying, inspecting, installing, integrating, maintaining, selling and/or servicing security, household fire warning, stand alone electro/mechanical, special locking and closed circuit television equipment and/or systems.

*Equipment Distributor*—Those firms and/or persons who sell security, locking and/or camera systems and equipment at wholesale to property protection contractors licensed per R.S. 40:1664.1 et seq. Equipment distributors shall not engage in property protection contracting without being properly licensed per this subpart.

*Firm*—a sole proprietorship, partnership, corporation, limited Liability Company or any other entity.

*Gate System Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of Pedestrian or Vehicle Gate systems and equipment.

*Health Care Locking Systems*—locking systems and equipment within a health care facility as outlined in NFPA 101 that provides security for the patient based on the clinical needs of the patient. These systems require an annual certification.

*Household Fire Warning Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity

of fire detection and alarm systems in one and two family dwellings.

*Household Fire Warning System*—fire detection and alarm systems consisting of standalone and/or interconnected devices intended to detect and warn occupants of fire, smoke, heat, and/or poisonous gases. The term includes, but is not limited to, heat detectors, smoke detectors and carbon monoxide detectors. Systems and equipment may be powered by direct or alternating current power.

*Inspection*—a visual examination of a system or portion thereof to verify that it appears to be in operating condition and is free of physical damage.

*Installation*—the initial placement of property protection equipment and systems or an addition, extension, or alteration after initial placement.

*Integration*—the act of developing a unified and functioning property protection system and/or equipment in accordance with manufacturers' specification and/or NFPA codes and standards.

*License*—that document issued by the state fire marshal to an employee of a certified firm authorizing the employee to engage in the activities as defined by these rules.

*Locksmith Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of stand alone electro/mechanical locks, closed circuit television or special locking systems and equipment.

*Maintenance*—work, including, but not limited to repair, replacement, and service, performed to ensure that equipment operates properly. It includes a thorough examination for physical damage or condition to prevent its operation and any necessary repair or replacement.

*Nationally Recognized Testing Laboratory*—a nationally recognized testing company concerned with product and service evaluation, which, after conducting successful examinations, inspections, tests and reexaminations, reflects approval by various labeling, listing and classification actions.

*NFPA*—the National Fire Protection Association, Inc., a nationally recognized standards-making organization.

*Officer*—the president, vice president, secretary, treasurer, comptroller, general manager or any other person who performs functions corresponding to such positions for a property protection firm.

*Operating Location*—a physical office which houses employees and business documents or records and from which the acts authorized by the certificate of registration are performed. The office must be open and accessible during normal work hours. Business records must be maintained for a minimum of years. The use of a storage facility, telephone answering service or Post Office Box shall not constitute a location for purposes of this subpart. The office must physically reside within the boundaries of Louisiana.

*Pedestrian Gate System*—access controls or barriers used to prevent unauthorized entry to a building or area. Pedestrian gates may be secured by either stand alone electro/mechanical locks or special locking systems and equipment. These systems require an annual certification.

*Person*—a natural individual, including any owner, manager, officer, or employee of any firm.

*Pocket license*—that document issued by the state fire marshal to an employee of a certified firm, in pocket size and bearing a photographic image of the licensee, authorizing the employee to engage in the activities as defined by these rules.

*Principal*—a person or entity that has a controlling interest of a property protection firm regardless of the form of organization. "Principal" includes a person or entity entitled to exercise the prerogatives or indicia of ownership or control of a property protection firm whether by direct action, assignment, or any other kind of substitution or subrogation.

*Property Protection Activity*—the act of certifying, designing, inspecting, installing, integrating, maintaining, selling and/or servicing of security, household fire warning, stand alone electro/mechanical locking, special locking and closed circuit television equipment and/or systems pursuant to R.S. 40:1664.1 et seq.

*Property Protection Equipment and Systems*—those systems and equipment designed to protect persons and property from the dangers of fire, theft, unauthorized entry or other harmful actions or events.

*Property Protection Sales and Design Endorsement*—that document issued by the state fire marshal to an employee of a certified property protection firm who designs or sells a property protection system or equipment.

*Qualifying Person*—the employee of a firm who currently meets the certification, examination and/or training requirements set for each endorsement by the Life Safety and Property Protection Advisory Board. A qualifier shall physically reside within 150 miles of the operating location and work a minimum of 32 hours per week. The qualifier must be actively engaged in the direct supervision of the daily property protection activities for the firm and its employees for which they are authorized to perform.

*Security Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of security, household fire warning, closed circuit television and/or special locking systems and equipment.

*Security Systems*—those assemblies of wiring, electronic transmitting devices, detection devices, and related equipment for the detection of theft, unauthorized entry or other physical harm to a structure's occupants or property.

*Sell*—to solicit on behalf of a property protection firm by any means for the sale or lease of a property protection system. The term includes, but is not limited to, solicitation via telephone or electronic devices, public notice or advertisement, door to door or any other type of personal interaction.

*Service*—the act of repair, bypass or replacement of property protection equipment/systems to ensure its proper functioning.

*Special Locking System*—electronic, magnetic and/or pneumatic locking systems and/or equipment actuated from a remote location. These systems are typically powered by the building power but may be battery powered only as well. The term includes, but is not limited to, access control, delayed egress, electrified hardware, magnetic locks, health care locks, pneumatic, pin, card reader, proximity, biometric,

video/telephone, electronically controlled egress door assemblies, pedestrian and vehicle gates and remote control and wireless access systems and equipment. This would include any necessary mechanical equipment to complete the installation of the system.

*Special Locking System Endorsement*—that document issued by the state fire marshal to a firm or employee authorizing either to engage in property protection activity of special locking systems and equipment.

*Stand Alone Electro/Mechanical Locks*—locks that are operated by electric, electronic and/or mechanical means. They may not be powered by the building power. Stand alone electro/mechanical locks shall only be actuated at and physically mounted on the door leaf. Stand alone electro/mechanical locks include, but are not limited to, hotel room door locks, battery operated locks, push button locks, self-powered door locks, key fob and combination locks. The term does not include special locking systems and equipment.

*Vehicle Gate Systems*—an access control system or barrier used to prevent unauthorized entry to a building or area. Vehicle gates may be secured by either stand alone electro/mechanical locks or special locking systems and equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3213. Certificates of Registration**

A. Every firm must obtain from the state fire marshal a certification of registration with the appropriate endorsements as provided for by R.S. 40:1664.1 et seq., before engaging in the property protection activity of security, household fire warning, stand alone electro/mechanical locks, special locking systems and closed circuit television equipment and/or systems.

1. Each firm, as defined by R.S. 40:1664.1 et seq., shall have at least one licensed technician per endorsement of certification to perform the act or acts authorized by its certificate.

2. Each firm, as defined by R.S. 40:1664.1 et seq., shall have at least one licensed qualifier per endorsement of certification to perform the act or acts authorized by its certificate. When a firm only has one technician, the technician can also be the qualifier.

3. Firms as defined by R.S. 40:1664.1 et seq., and their owners shall be responsible for the acts of their agents and employees for the purpose of these rules including the initiation of administrative action by the state fire marshal.

B. The following shall apply to certificates of registration.

1. Posting. Each certificate shall be posted conspicuously at each firm and/or branch office premises.

2. Changes of Ownership. The change of a firm's majority ownership invalidates the current certificate. To assure continuance of the firm's ability to conduct property protection contracting, an application for a new certificate shall be submitted to the state fire marshal within 10 days after such change in ownership.

3. Change of Corporate Officers. Any change of corporate officers within the licensure period, must be reported in writing to the state fire marshal within 10 days of

the change. This change does not require a revised certificate.

4. Duplicates. A duplicate certificate must be obtained from the state fire marshal to replace a lost or destroyed certificate. The certificate holder must submit written notification of the loss or destruction within 10 days, accompanied by the required fee specified in these rules.

5. Revisions/Changes. The change of a firm's name, location, or mailing address or operating status requires a revision of the certificate of registration. Certificates of registration requiring changes must be surrendered to the state fire marshal within 10 days after the change requiring the revision. The firm must submit written notification of the change with the surrendered certificate of registration, accompanied by the required fee specified in by R.S. 40:1664.1 et seq.

6. Non-Transferability. A certificate of registration is not transferable from one firm to another.

7. Validity. A certificate of registration is valid for one year from date of issue, and must be renewed annually.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3215. Licensure**

A. Required. Each person who engages in property protection activity of security, household fire warning, stand alone electro/mechanical locks, special locking systems and closed circuit television equipment and/or systems shall have a current and valid license issued by the state fire marshal.

B. Types of Endorsement. Each license shall be identified by endorsement, which indicates the authorized act or acts which may be performed by the licensee.

C. Posting. It is not necessary to post an employee license on a wall. A master list of all employees' names and license numbers must be kept at each office location and must be available for review upon request by the state fire marshal or his designated representative.

D. Pocket License. The pocket license is for immediate identification purposes only so long as such license remains valid and while the holder is employed by the firm reflected on the license and shall be on his/her person at all times when conducting property protection activity in the field. The pocket license need not be visibly displayed when working in areas where the license may be damaged or lost. The license must still be available for inspection upon request.

E. Duplicate License. A duplicate license must be obtained from the state fire marshal to replace a lost or destroyed license. The license holder and his employer must submit written notification within 10 days of the loss or destruction of a license, accompanied by the required fee as specified in these rules.

F. Revised Licenses. The change of a licensee's employer, home address or mailing address or employment status requires a revised license. Licenses requiring revision must be surrendered to the state fire marshal within 10 days after the change requiring the revision. The license holder and his employer must submit written notification of the necessary change with the surrendered license, accompanied by the required fee as specified in these rules.

G. Non-Transferable. A license is not transferable from one person to another or from one firm to another.

H. License Reciprocity. The state fire marshal may waive license requirements for an applicant with a valid license from another state if that state has license requirements substantially equivalent to Louisiana and which recognizes licenses issued by this office.

I. Validity. A license is valid for one year from date of issue, and must be renewed annually, unless the state fire marshal adopts a system under which licenses expire on various dates during the year. Should a staggered renewal system be adopted, the renewal fees shall be prorated on a monthly basis so that each licensee pays only that portion of the fee that is allocable to the number of months during which the license is valid.

J. Transfer of Employer. When a currently licensed employee transfers to a new employer, a revised license shall be required indicating the new firm's information. The license shall be revised to show the same expiration date of the new employer. Upon receipt of the revision application by the state fire marshal, the individual may go to work for the new employer while waiting the processing of the license. This go-to-work allowance shall not authorize the employee to engage in property protection activity for which he/she was not previously licensed to perform or for which the firm is not currently registered to perform.

K. Age Limitations. For the purpose of licensing, no one under the age of 18 shall be eligible for a technician's license and no person under the age of 16 shall be eligible for an apprentice license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3217. Alteration of Certificates or Licenses**

A. Any alteration of a certificate of registration or license renders it invalid and such alteration shall be the basis for administrative action in accordance with penalties set forth in R.S. 40:1664.1 et seq., and these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3219. Application for Certificates of Registration**

A. Applications for a certificate of registration for Life Safety and/or Property protection firms shall be in writing on the forms provided by the state fire marshal and accompanied by the required fee as specified in these rules.

B. The application for certificates of registration shall:

1. be executed by the sole proprietor, or by each partner of a partnership, or by the authorized officer of the firm;
2. identify the type of endorsement applied for;
3. identify the physical and mailing address, if different, of the firm's operating location;
4. identify any and all names by which the firm may conduct activity regulated by R.S. 40:1664.1 et seq., and these rules. Only one trade or "Doing Business As" name shall be permitted per each certificate of registration;
5. identify each principal and officer of the firm;
6. identify the contact person and email address of such, as defined by these rules;

7. identify the qualifying person for each endorsement applied for;

8. identify any and all past violations or pending administrative action against the firm in other jurisdictions;

9. include a separate employee application for each qualifying person along with the required training or certification credentials as established by the Life Safety and Property Protection Advisory Board and an originally signed and notarized employment affidavit. A firm must employ and license at least one qualifier. Multiple qualifiers may be licensed;

10. be accompanied by:

a. at least one application with fee from an employee seeking to obtain a technician's license in each endorsement;

b. a current certificate of insurance issued to the Office of State Fire Marshal showing a minimum of \$500,000 coverage;

c. a copy of the local or occupational license for the firm.

C. The application shall also include written authorization by the applicant permitting the state fire marshal or his representative to enter, examine, and inspect any premise, building, room, vehicle, or establishment used by the applicant while engaged in property protection activity to determine compliance with the provisions of R.S. 40:1664.1 et seq., and these rules.

D. When the applicant has completed the requirements contained above, a pre-certification inspection may be conducted at the facilities or of the vehicles of the applicant for verification of compliance with this subpart. The office may inspect vehicles, equipment, buildings, devices, premises or any other area to be used in performing the activities allowed by the certificate of registration. After issuance of a certificate of registration, such facilities may be inspected annually thereafter or as frequently as deemed necessary to ensure that the equipment requirement continues to be met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3221. Qualifying Persons**

A. Each certified firm or each firm seeking certification shall employ at least one qualifying person for each endorsement it is making application for. No property protection system or equipment shall be certified, inspected, installed, integrated, maintained, serviced, sold, or submitted to the state fire marshal for review if the firm does not employ a qualifying person as provided herein.

B. The qualifying person shall be a paid employee working a minimum of 32 hours per week and shall receive a W-2 or K-1 tax form from the firm. The qualifier shall only qualify one firm for which he is employed. An individual may not qualify multiple firms at the same time. A contract employee cannot be used to fulfill this requirement except as provided by subsection G below. A qualifier must physically reside within 150 miles of the office for which he or she qualifies.

C. The qualifying person shall be primarily and actively engaged in direct supervision of the daily property

protection activity of the firm's employees and for those systems or equipment for which the firm holds endorsements for. If a firm holds multiple endorsements, then multiple qualifiers may be utilized to meet this requirement. Upon request by the state fire marshal or his representative(s), a qualifier shall provide documentation attesting to his or her supervision of any certification, integration, inspection, installation, maintenance or service performed by the firm he or she qualifies.

D. A qualifier must meet the minimum examination, certification, or training requirements as established by the Life Safety and Property Protection Advisory Board. The state fire marshal shall send notice to licensed firms of all changes to qualifier credentials made by the Life Safety and Property Protection Advisory Board.

E. At anytime that a firm finds itself without a qualifying person, such firm shall only be able to continue certifying, inspecting, maintaining and/or servicing existing contractual obligations for that endorsement but shall not engage in any new work until a qualifying person has been employed as provided herein. A firm may not submit plans to the Office of the State Fire Marshal when it finds itself without a qualifying person.

F. This office shall be notified in writing within 10 working days anytime a qualifying person's employment is terminated for any reason.

G. A firm which loses its qualifying person and has timely notified the Office of the State Fire Marshal shall have 90 days to hire another qualifying person. If after the loss of such an employee, a replacement cannot be found within the 90 days, the firm may make a request to the Office of the State Fire Marshal to temporarily hire a qualifying person on a contractual basis. Good cause must be shown why another employee cannot be permanently hired. Approval by the Office of the State Fire Marshal for the hiring of a qualifying person on a contractual basis shall not exceed six months. Not later than 30 days prior to the expiration of the six-month period, the firm may request an additional six-month period to employ a qualifying person on a contractual basis if good cause is shown why the firm cannot hire an employee to fulfill this requirement. The Office of the State Fire Marshal may grant one additional six-month period during which a firm may employ a qualifying person on a contractual basis.

H. Failure to notify this office in writing within 10 working days of the loss of a qualifying person will cause forfeiture of any extension of time to hire another qualifying person.

I. A qualifying person must obtain an individual employee license as required by these rules. Licensure of the qualifier shall include a signed and notarized affidavit indicating the employment relationship and duties of the qualifier. If a firm desires to use multiple qualifiers for submitting plans and supervising the property protection activity of the firm, then it must register and license the additional qualifiers with the Office of the State Fire Marshal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3223. Application for Licenses**

A. Applications for a license from an employee of a certified firm shall be on forms provided by the state fire marshal and accompanied by the required fee as specified in these rules.

B. Applications for individual licenses shall be accompanied by a written statement from the employer certifying the applicant's competency to perform property protection activity of the systems and equipment authorized by the endorsements applied for and that the individual is an employee who receives a W-2 or K-1 tax form from the firm.

C. Identify the type of endorsement applied for.

D. Identify the physical and mailing address, if different, of the individual's home address.

E. Identify any and all names by which the individual may have conducted activity regulated by R.S. 40:1664.1 et seq., and these rules, if not the same on the application.

F. Identify any and all past felony convictions, first-time offender pardons for a felony, and pleas of guilty or *nolo contendere* to a felony charge.

G. Identify any and all past violations or pending administrative action against the individual in other jurisdictions.

H. Unless a provisional license is issued, applications for individual licenses will not be accepted unless accompanied by documentation showing that the applicant has met all competency requirements as determined by the Life Safety and Property Protection Advisory Board.

I. No competency examination or training is required for an apprentice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3225. Fees—General Information**

A. Every fee required in accordance with the provisions of R.S. 40:1664.1 et seq., and these rules, shall be paid by firm check or certified funds made payable to the "Office of State Fire Marshal." Cash or personal checks cannot be accepted.

B. Fees shall be paid at or mailed to the Office of the State Fire Marshal, Attention Licensing Section, at 8181 Independence Blvd., Baton Rouge, Louisiana 70806.

C. Late fees are required on all certificates of registration or licenses which are not timely renewed as outlined in R.S. 40:1664.1 et seq.

D. A renewal application accompanied by the required renewal fee and deposited with the United States Postal Service is deemed to be timely filed, regardless of actual date of delivery, when its envelope bears a legible postmark date which is on or before the expiration date of the certificate or license being renewed.

E. Certificates or licenses which have been expired for more than 60 days will be suspended and applicants must apply and pay for a new certificate of registration or license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3227. Fees—Specific Information**

A. Certificate of Registration Fees for Firms

	Initial	Renewal
<b>Technical Endorsement</b>		
Security	\$250	\$50
Locksmith	\$250	\$50
Door Hardware	\$250	\$50
<b>Specialty Endorsement</b>		
Household Fire	\$250	\$50
CCTV	\$250	\$50
Door Hardware Consultant	\$250	\$50
Bank Locking	\$250	\$50
Special Locking	\$250	\$50
Detention Locking	\$250	\$50
Gate Systems	\$250	\$50

B. License Fees for Employees

	Initial	Renewal
<b>Technical Endorsement</b>		
Security	\$100	\$50
Locksmith	\$100	\$50
Door Hardware	\$100	\$50
<b>Specialty Endorsement</b>		
Household Fire	\$100	\$50
CCTV	\$100	\$50
Door Hardware Consultant	\$100	\$50
Bank Locking	\$100	\$50
Bank Auxiliary	\$100	\$50
Special Locking	\$100	\$50
Detention Locking	\$100	\$50
Gate Systems	\$100	\$50
Property Protection Sales and Design	\$100	\$50
Apprentice	\$50	\$50

C. Late Renewal Fee. A penalty shall be assessed in accordance with R.S. 40:1664.2 et seq., for the late renewal of a certificate of registration or license.

D. Change in ownership: \$250.

E. Changes or alterations: \$20.

F. Duplicate certificates of registration or license: \$20.

G. Replacement pocket registration card: \$20.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3229. Initial Licensing Training Certification, Continuing Education**

A. Initial Training Certification. Applicants for an individual initial license are required to meet the initial training certification requirements as established by the Life Safety and Property Protection Advisory Board.

B. Continuing Education. Applicants for an individual license who wish to renew their licenses are required to meet the continuing education requirements as established by the Life Safety and Property Protection Advisory Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### §3231. Property Protection Systems and Equipment

A. All property protection systems and equipment shall be certified, designed, installed, integrated, maintained or serviced in a manner that maintains the highest level of operation afforded by the manufacturer of the product.

B. All property protection systems and equipment shall be certified, designed, installed, integrated, maintain or serviced in a manner that meets all applicable codes and/or standards enumerated in LAC 55:V.103 or these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### §3233. Smoke Inducing Security Systems

A. Where a smoke inducing (fog systems) security system is installed in a commercial business, the installing firm shall notify all local law enforcement and fire service agencies in that jurisdiction which have responsibility for response to the business.

B. Such notification shall be in writing and a copy of such shall be maintained at the firm's office located in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### §3235. Installation Tags

A. Upon installation of any special locking system, the system shall have a tag permanently affixed to the control panel or at the connection to the power source. The installation tag shall be a minimum of 2 3/4 inches by 2 3/4 inches. Maximum size cannot exceed 5 inches by 5 inches. The tag shall be white in color and have a self adhesive backing. The following information and wording shall be required to be preprinted on the front side of the tag:

1. "DO NOT REMOVE BY ORDER OF THE STATE FIRE MARSHAL" (all capital letters, in bold type);
2. installation tag;
3. installation date;
4. firm's name;
5. firm's certificate number;
6. technician's name;
7. technician's license number;
8. technician's signature;
9. NFPA code edition system was installed under;
10. plan review or exemption number;
11. serial or model number of panel, if applicable.

B. All tags shall have a signature line for the technician to sign the tag upon completion of the work. No preprinted signatures are permitted. Technicians must sign the tag; initials are not permitted. Other information to be completed on the tag may be either handwritten or preprinted. Apprentices are not permitted to sign tags.

C. If after initial installation a control panel is replaced for any reason, a new installation tag shall be completed and attached as above, noting the appropriate changes in information.

D. Copies of certificates of compliance required to be completed by this office shall be attached to the system in a plastic pocket pouch/sleeve or given to the owner for filing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### §3237. Certification Tags, Service Tags, Partial Impairment Tags, Impairment Tags (Special Locking Systems and Equipment Only)

#### A. Certification Tags (Green Tags)

1. All firms engaged in property protection activity of special locking systems and equipment shall have a certification tag which shall be completed and attached to a special locking system, after it has been certified, inspected, installed, or integrated indicating all work that has been done.

2. Certification tags shall be green in color.

3. The certification tag shall be attached at the control panel or if no panel, at the connection to the power source (breaker panel).

4. The certification tag shall be attached in such a way as to not hamper the actuation and operation of the equipment or system.

5. A certification tag shall be attached on all systems or equipment found to be in proper working condition and which are found to be in an operational condition per the inspection, testing and maintenance chapters of the applicable NFPA codes and standards. This tag shall be used for new installations and shall be in addition to the installation tag provided for in these rules.

6. Certification tags must contain all of the information listed below. Information shall be preprinted on the tag unless noted otherwise:

- a. "DO NOT REMOVE BY ORDER OF THE STATE FIRE MARSHAL" (all capital letters in bold face type);
- b. firm's name, physical address and telephone number;
- c. firm's state fire marshal certificate number;
- d. technician's name and state fire marshal license number to be printed on tag either at the time of service or preprinted;
- e. technician's signature to be signed at time of service (no preprinted signatures nor initials are permitted; apprentices are not permitted to sign tags);
- f. day, month and year in which the certification was performed (must be punched through certification tag at designated marks for day, month and year; designated marks for day, month and year shall only be punched once per tag);
- g. type of work performed. Only installation or certification shall be noted on tag for type of work performed (must be punched through the certification tag);
- i. "Installation" shall be punched on the tag when the special locking system or equipment is initially placed into use or after an addition or extension to the system has been made. Punching "Installation" indicates the initial certification of the system or equipment has been completed;
- ii. "Certification" shall be punched on the tag when the special locking system or equipment has its annual inspection. Punching "Certification" indicates that any required service performed to the system or equipment at the time has been completed;
- iii. specifics as to the type of work performed shall be noted on rear of tag, (i.e. new installation, annual certification, etc);
- h. serial number of special locking system's control panel if present;

i. owner of system and address of owner (to be noted on rear of tag).

7. Other information may be permitted on the tag after a review and approval by the fire marshal. A request for additional information shall be made to the fire marshal in writing with a sample tag indicating the requested additions.

#### B. Service Tags (Blue Tags)

1. All firms engaged in property protection activity of special locking systems and equipment shall have a service tag which shall be completed and attached to a special locking system, after it has been maintained or serviced indicating all work that has been done.

2. Service tags shall be blue in color.

3. The service tag shall be attached at the control panel or if no panel, at the connection to the power source (breaker panel).

4. The service tag shall be attached in such a way as to not hamper the actuation and operation of the equipment or system.

5. A service tag shall be attached on all systems or equipment found to be in proper working condition after maintenance or service and which are found to be in an operational condition per the inspection, testing and maintenance chapters of the applicable NFPA codes and standards. This tag shall also be used for all service and maintenance where the system is found to meet the above conditions.

6. Service tags must contain all of the information listed below. Information shall be preprinted on the tag unless noted otherwise;

a. "DO NOT REMOVE BY ORDER OF THE STATE FIRE MARSHAL" (all capital letters in bold face type);

b. firm's name, physical address and telephone number;

c. firm's state fire marshal certificate number;

d. technician's name and state fire marshal license number to be printed on tag either at the time of service or preprinted;

e. technician's signature to be signed at time of service (no preprinted signatures nor initials are permitted; apprentices are not permitted to sign tags);

f. day, month and year in which service was performed (must be punched through service tag at designated marks for day, month and year; designated marks for day, month and year shall only be punched once per tag);

g. type of work performed. Only "Service" shall be noted on tag for type of work performed;

i. "service" tags shall be used when the special locking system or equipment is repaired or replaced to ensure proper operation in between required certification periods;

ii. specifics as to the type of work performed shall be noted on rear of tag (i.e. changed push button, repaired motion detector, etc);

h. serial number of special locking system's control panel if present;

i. owner of system and address of owner (to be noted on rear of tag).

7. Other information may be permitted on the tag after a review and approval by the fire marshal. A request for additional information shall be made to the fire marshal in writing with a sample tag indicating the requested additions.

#### C. Partial Impairment Tags (Yellow Tags).

1. All firms engaged in property protection activity of special locking systems and equipment shall be allowed to have a partial impairment tag, to be yellow in color, which is to be used when minor deficiencies are found on the equipment or system. The partial impairment tag is in addition to the requirement of having a service tag and impairment tag.

2. A partial impairment tag may be placed on all equipment or systems in which there is a deficiency with the equipment or system but where the equipment or system is still functional. This would include situations where routine service is needed but has not been approved by the owner of the equipment or system.

3. A partial impairment tag shall not remain on equipment or a system for more than 60 days. If the problem is not corrected after 60 days the certified firm shall be required to notify, in writing, the Office of the State Fire Marshal Inspection Section. The firm does not have to physically return to the building for re-inspection. The mailing of the impairment notice is sufficient.

4. Partial impairment tags must contain all of the information listed below. Information shall be preprinted on the tag unless noted otherwise:

a. "DO NOT REMOVE BY ORDER OF THE STATE FIRE MARSHAL" (all capital letters in bold face type);

b. firm's name, physical address and telephone number;

c. firm's state fire marshal certificate number;

d. technician's name and state fire marshal license number to be printed on tag either at the time of service or preprinted;

e. technician's signature to be signed at time of inspection (no preprinted signatures nor initials are permitted; apprentices are not permitted to sign tags);

f. day, month and year in which the impairment was found (to be punched through service tag at designated marks for day, month and year; designated marks for day, month and year shall only be punched once per tag);

g. type of impairment found (to be hand written on rear of tag); If additional space is needed to note the impairments, then multiple tags shall be used noting 1 of 2, 2 of 2, etc.;

h. serial number of special locking system's control panel if present;

i. business owner or tenant and physical address of where the system is located (to be noted on rear of tag).

#### D. Impairment Tags (Red Tags)

1. All firms engaged in property protection activity of special locking systems and equipment shall have an impairment tag, to be red in color, which is to be used when major deficiencies are found on these systems or equipment.

2. An impairment tag shall be placed on all special locking systems upon discovery that the system or equipment is impaired to the point that life safety is at risk or to the point that the automatic or manual release on the system will be prevented from functioning as intended.

3. Impairment tags shall also be placed on any equipment or system where life safety is in imminent danger.

4. Written notice shall be made to the owner and to the Office of the State Fire Marshal Inspection Section by the certified firm as soon as is practically possible but shall

not exceed two working days after the system or equipment is red tagged. Notification to the Office of the State Fire Marshal is not needed for fire hoses removed from service. Written notification can be by electronic mail or facsimile. The Office of State Fire Marshal shall provide a form for notification. Additional notification (written or verbally) should be made to the local fire department when a system is red tagged.

5. Impairment tags must contain all of the information listed below. Information shall be preprinted on the tag unless noted otherwise:

a. "DO NOT REMOVE BY ORDER OF THE STATE FIRE MARSHAL" (all capital letters in bold face type);

b. firm's name, physical address and telephone number;

c. firm's state fire marshal certificate number;

d. technician's name and state fire marshal license number to be printed on tag either at the time of service or preprinted;

e. technician's signature to be signed at time of inspection (No preprinted signatures nor initials are permitted.) (Apprentices are not permitted to sign tags.);

f. day, month and year in which the inspection was performed (to be punched through service tag at designated marks for day, month and year; designated marks for day, month and year shall only be punched once per tag);

g. type of impairment found (to be hand written on rear of tag); if additional space is needed to note the impairments, then multiple tags shall be used noting 1 of 2, 2 of 2, etc.;

h. serial number of special locking system's control panel if present;

i. business owner or tenant and physical address of where the system is located (to be noted on rear of tag).

6. Notification of special locking equipment/systems inspections where no deficiencies are found need not be sent to the Office of the State Fire Marshal unless specifically requested.

E. Written Notification. The following information is required to be sent when written notification is made to the Office of the State Fire Marshal Inspection Section:

1. name, address, and telephone number of the owner of the system;

2. name, address, telephone number, and certificate number of the firm noting the impairment;

3. name and license number of the technician who did the certification, inspection, maintenance, or service;

4. type of system (manufacturer and model number should also be included);

5. the name and year edition of the code or standard the firm used for inspection;

6. reason for the impairment. Note: A copy of the inspection or service report shall be included; and

7. date system or equipment was red or yellow tagged.

F. Other Requirements

1. On all special locking systems, a plastic pocket pouch/sleeve shall be attached to the control panel, or near the power source when no control panel is installed, where all tags shall be maintained for a period of one year after the system's annual certification. Upon a new annual certification, all previous service tags may be removed and given to the owner to keep on file.

2. All tags must be card stock, plastic, vinyl, tyevak or metal in order to maintain the running record for the system.

3. All tags shall be 5 1/4 inches in height and 2 5/8 inches in width.

4. Firms shall have their tags printed and one forwarded to the state fire marshal's Licensing Section for approval and incorporation in the firm's file.

5. Tags may be removed only by licensed employees of a certified firm or employees of the state fire marshal's Office and certified fire prevention bureaus.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3239. Door to Door Solicitation**

A. All door to door solicitations shall comply with the following:

1. all local permitting ordinances and requirements;

2. vehicles shall be properly marked with the firm's name and certificate number;

3. all advertisements, invoices, literature, business cards and letter head must include the firm's certificate number and Louisiana address.

B. All firms conducting door to door solicitations shall be required to notify, in writing, the Office of the State Fire Marshal Licensing Section of such. Such notice shall include, the city, time frame of such solicitation and an affirmation that all local solicitation ordinances have been met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3241. Fair and Ethical Business Practices**

A. Property protection firms and employees shall conduct all business practices in compliance with all applicable laws.

B. Property protection firms and employees shall impartially analyze safety or security problems of their customers and advance the best possible solution for the protection of the customer.

C. Property protection firms and employees shall not misrepresent any business claims to the customer.

D. Property protection firms and employees shall not misrepresent the features afforded by any product nor make unwarranted claims about the merits of any product or service they offer. Examples include, but are not limited to the following:

1. representing to a client that non-restricted or widely available keys (whether stamped "Do Not Duplicate" or not) provide any measure of assurance against unauthorized duplication;

2. selling a used product as new;

3. claiming the customer's existing equipment is out of date or substandard when it is not.

E. Property protection firms and employees shall avoid using any improper or questionable means of soliciting business. Prohibited practices include, but are not limited to:

1. affixing stickers to permanent fixtures such as doors or door frames or in any way defacing the property of any person without his express consent;

2. installing stickers or any other promotions in such fashion that they falsely represent that the firm has previously serviced the system or equipment in that location;

3. installing or supplying systems or equipment which curtails the customer's ability to choose a different company or technician for product support or service, unless the firm obtains the customer's expressed written consent;

4. modifying the customer's hardware in any fashion that will curtail the customer's ability to choose a different company or technician for later product support or service or cause him to incur additional expense by doing so, unless the firm obtains the customer's express written consent;

5. claiming the customer's current contractor is out of business when it is not.

F. Property protection firms and employees shall not directly solicit in violation of a no compete agreement, such as an employee offering competing bids to customers of his employer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3243. Prohibited Acts and Equipment**

A. The following acts are prohibited and shall be considered grounds for administrative action to be taken against firms, persons and/or employees committing such:

1. charging a customer for work that was not performed;

2. misrepresenting oneself and/or one's firm to a customer, prospective customer or to employees of the state fire marshal, his designated representative or other public official;

3. impersonating the state fire marshal, his designated representative or any other public official;

4. intimidating or coercing a customer;

5. certifying, inspecting, installing, integrating, maintaining or servicing property protection systems and/or equipment contrary to plans submitted for review, applicable NFPA codes, standards, and/or manufacturer's specifications without specific written permission from the Office of the State Fire Marshal;

6. falsifying an application or any other document submitted to obtain a certificate or license or other documentation requested by or submitted to the Office of the State Fire Marshal;

7. falsifying tags, labels, inspection reports, invoices, system reports and/or other documents;

8. working an apprentice, or as an apprentice, without direct supervision by a technician licensed to perform the work being done and licensed to the same firm;

9. working an employee without the appropriate endorsement of license;

10. working without the appropriate endorsement of firm certificate or license;

11. working with an expired firm certificate or license;

12. failing to notify the Office of the State Fire Marshal of any changes that affect licensure;

13. failing to notify local law enforcement or fire service agencies of the installation of a smoke inducing security system;

14. contracting to a firm or person who is not properly certified or licensed through the Office of the State Fire

Marshal to perform acts regulated by the provisions of R.S. 40:1664.1 et seq., or these rules;

15. failing to adhere to the tagging and/or notification policies of the Office of the State Fire Marshal;

16. installing a special locking system prior to submitting plans and required documentation and receiving authorization to install such system from the Plan Review Section of the Office of the State Fire Marshal;

17. failing to possess the equipment, tools, NFPA codes, standards or manufacturer's UL listed installation and service manuals to properly certify, inspect, install, integrate, maintain or service the systems or equipment for which a firm is certified;

18. failing to adhere to all applicable laws and rules governing property protection systems and/or equipment as promulgated by the Office of the State Fire Marshal;

19. engaging in false, misleading or deceptive acts or unfair or unethical business practices;

20. aiding and abetting an unlicensed person or firm to engage in property protection activity;

21. aiding and abetting a person or firm to certify, install, inspect, or service property protection systems or equipment contrary to code or manufacturer specifications;

22. failing to adhere to local ordinances regarding solicitation, permitting and occupational licensing and activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3245. Enforcement**

A. The state fire marshal or his designated representative, shall make, or cause to be made, from time to time, inspections of a firm's physical locations, vehicles or job sites to verify required certificates, employee lists, employee licenses, business records and insurances, equipment, tools, NFPA codes, standards and manufacturer's manuals and property protection activity performed, and as circumstances dictate, to determine that firms and their employees are engaging in activity in accordance with the requirements of R.S. 40:1664.1 et seq., and these rules.

B. The state fire marshal shall investigate all complaints of alleged violations of R.S. 40:1574 et seq., 40:1664.1 et seq., and these rules. Complaints of alleged violations shall be made in writing to the Licensing Section of the state fire marshal's office. The Office shall make available a complaint form to be used as needed. Penalties shall be administered to those firms and/or employees found to have violated these laws and/or rules. Proposed administrative penalty letters shall act as official notification of alleged violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3247. Administrative Actions**

A. The state fire marshal may refuse the issuance or renewal of, suspend, or revoke a certificate of registration, or license and impose administrative penalties, if, after notice, as provided for by the Administrative Procedures Act, it is found that a person, certified firm, or licensee or an applicant for registration, or license, failed to comply with the provisions of R.S. 40:1664.1 et seq., or these rules. The

state fire marshal may consider violations in other states or failing to pay outstanding fine amounts as grounds for refusing the issuance of or the renewing of a certificate of registration or license. Additionally, where it is brought to the attention of the state fire marshal, violations in other states or failing to pay outstanding fine amounts may result in the suspension of or revocation of a certificate of registration or license.

1. Offenses. The following categories shall denote classification of offenses for persons, firms and employees for determining the penalty to be imposed:

- a. minor:
  - i. failing to notify the Office of the State Fire Marshal of any changes that affect licensure;
  - ii. Failing to adhere to the tagging and/or notification policies of the Office of the State Fire Marshal;
  - iii. working with an expired (31-45 days) license or certificate of registration;
  - iv. failing to properly display a firm certificate;
- b. serious:
  - i. failing to notify local law enforcement or fire service agencies of the installation of a smoke inducing security system;
  - ii. working an apprentice, or as an apprentice, without direct supervision by a technician licensed to perform the work being done and licensed to the same firm;
  - iii. working an employee without the appropriate endorsement of license;
  - iv. working without the appropriate endorsement of firm certificate or license;
  - v. working with an expired (46-60 days) license or firm certificate;
  - vi. contracting to a firm or person who is not properly certified or licensed through the Office of the State Fire Marshal to perform acts regulated by the provisions of R.S. 1664.1 et seq., or these rules;
  - vii. failing to possess the equipment, tools, NFPA codes, standards or manufacturer's UL listed installation and service manuals to properly certify, inspect, install, integrate, maintain or service the systems or equipment for which a firm is certified;
  - viii. failing to adhere to local ordinances regarding solicitation, permitting and occupational licensing activities;
  - ix. committing five or more minor offenses within a three-year period;
- c. major:
  - i. charging a customer for work that was not performed;
  - ii. impersonating the state fire marshal, his designated representative or any other public official;
  - iii. intimidating or coercing a customer;
  - iv. misrepresenting oneself and/or one's firm to a customer, prospective customer or to employees of the Office of the State Fire Marshal, his designated representative or other public official;
  - v. falsifying an application or any other document submitted to obtain a certificate or license or other documentation requested by or submitted to the Office of the State Fire Marshal;
  - vi. falsifying tags, labels, inspection reports, invoices and/or other documents;

vii. working without any or with a suspended firm certificate of registration or license;

viii. working an employee with a suspended license;

ix. aiding and abetting an unlicensed person or firm to engage in property protection activity.

x. certifying, inspecting, installing, integrating, maintaining or servicing special locking systems and/or equipment contrary to plans submitted for review, applicable NFPA codes, standards, and/or manufacturer's specifications without specific written permission from the Office of the State Fire Marshal;

xi. aiding and abetting a person or firm to certify, install, inspect, or service property protection systems or equipment contrary to code or manufacturer specifications;

xii. installing a special locking system or equipment prior to submitting plans and required documentation and receiving authorization to install such system from the Plan Review Section of the Office of the State Fire Marshal;

xiii. committing three or more Serious offenses within a three year period;

xiv. engaging in false, misleading or deceptive acts or unfair or unethical business practices.

2. Penalties. The following fine schedule shall be used to assess fines to persons, firms, and/or employees who violate the laws and rules governing property protection activity. Penalties will be imposed to persons, firms and/or employees based on the classification of offense. Each classification of offense will have a minimum and maximum fine shown and any other administrative penalty that may be imposed.

a. Firms and/or persons

i. minor: \$50 fine to \$250 fine and/or official warnings may be imposed;

ii. serious: \$250 fine to \$1,000 fine and/or suspensions of up to 90 days may be imposed;

iii. major: \$1,000 fine to \$5,000 fine and/or suspensions from 91 to 365 days may be imposed and/or revocation of certificate may be imposed.

b. Employees and/or persons:

i. minor: \$10 fine to \$50 fine and/or official warnings may be imposed;

ii. serious: \$50 fine to \$500 fine and/or suspensions of up to 90 days may be imposed;

iii. major: \$500 to \$5,000 fine and/or suspensions from 91 to 365 days may be imposed and/or revocation of license may be imposed.

c. The state fire marshal may deviate from this fine schedule where circumstances and/or evidence warrant a more stringent or more lenient penalty.

d. In lieu of fine payments, the state fire marshal may require remedial or additional training be obtained by those found in violation.

e. Those offenses not enumerated in this list shall receive penalties for violations of similar nature.

f. The Office of the State Fire Marshal may also pursue criminal charges or injunctive relief for any of the above enumerated offenses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3249. Severability**

A. If any provision of these rules or the application thereof to any firm, person, employee or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these rules which can be given effect without the invalid provisions or application. To this end, all provisions of these rules are declared to be severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3251. Adopted Standards**

A. The office adopts by reference in their entirety those copyrighted codes or standards enumerated in LAC 55:V:103 published by and available from the National Fire Protection Association, Inc.(NFPA), Batterymarch Park, Quincy, Massachusetts, 02268. A copy of the codes and standards shall be kept available for public inspection in the Office of the State Fire Marshal. In addition to those listed standards, the following shall also be adhered to as applicable:

1. ASME/ANSI A17.1—Safety Code for Elevators and Escalators;
2. ASME/ANSI A17.3—Safety Code for Existing Elevators and Escalators;
3. ASME/ANSI A117.1—Specifications for Handicapped Accessibility;
4. ADAAG—American Disability Accessibility Act Guidelines;
5. United States Department of Transportation;
6. Code of Federal Regulations 49.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3253. National Recognized Testing Laboratory**

A. This office approves Underwriters Laboratories, Inc., Factory Mutual Research Corporation, the United States Testing Company, Inc. and Intertek-ETL as nationally recognized testing laboratories for the purpose of these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**§3255. Equipment and Facilities**

A. Each certified firm location shall be required to possess the equipment, tools, NFPA codes, standards and manufacturer's UL listed installation and service manuals necessary to properly certify, inspect, install, integrate, maintain or service the systems or equipment for which it is certified. Required codes, standards and manuals may be either in print or in an electronic format.

B. The following equipment and code books shall be required depending upon the firm's certification endorsement:

1. security:
  - a. certification, service, partial impairment (optional) and impairment tags;
  - b. installation tags;

- c. NFPA 70, 72, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
- d. copy of life safety and property licensing law and rules;
- e. manufacturer's installation manuals;
- f. sound level meter;
2. household fire warning:
  - a. NFPA 70, 72 and 101 (latest edition as enumerated in LAC 55:V.103);
  - b. copy of life safety and property licensing law and rules;
  - c. manufacturer's installation manuals;
  - d. sound level meter;
3. closed circuit television:
  - a. NFPA 70 (latest edition as enumerated in LAC 55:V.103);
  - b. copy of life safety and property licensing law and rules;
  - c. manufacturer's installation manuals;
4. locksmith:
  - a. certification, service, partial impairment (optional) and impairment tags;
  - b. installation tags;
  - c. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - d. copy of life safety and property licensing law and rules;
  - e. manufacturer's installation manuals;
5. bank locking:
  - a. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - b. copy of life safety and property licensing law and rules;
  - c. manufacturer's installation manuals;
6. detention locking:
  - a. certification, service, partial impairment (optional) and impairment tags;
  - b. installation tags;
  - c. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - d. copy of life safety and property licensing law and rules;
  - e. manufacturer's installation manuals;
7. door hardware:
  - a. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - b. copy of life safety and property licensing law and rules;
  - c. manufacturer's installation manuals;
8. door hardware installation:
  - a. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - b. copy of life safety and property licensing law and rules;
  - c. manufacturer's installation manuals;
9. special locking:
  - a. certification, service, partial impairment (optional) and impairment tags;
  - b. installation tags;
  - c. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);

- d. copy of life safety and property licensing law and rules;
  - e. manufacturer's installation manuals;
10. gate systems:
- a. certification, service, partial impairment (optional), and impairment tags;
  - b. installation tags;
  - c. NFPA 70, 80 and 101 (latest edition as enumerated in LAC 55:V.103);
  - d. copy of life safety and property licensing law and rules;
  - e. manufacturer's installation manuals.

C. The state fire marshal or his representative(s) may inspect a firm's physical location(s) or vehicle(s) to ensure the proper equipment, tools, NFPA codes, NFPA standards, manufacturer's UL listed installation and service manuals and business records and insurances are possessed by the firm. Firms must possess all applicable manufacturers' installation and service manuals for the systems and/or equipment it services.

D. Each Louisiana operating location must house all business records of the firm. Business records may be either electronic or hard copies. Business records shall include, but not be limited to, invoices, work orders, service reports, payroll records, federal and state tax information for employees, occupational licenses, local solicitation permits, income tax filings, property tax notifications and filings, utility records, certificates of insurance for general liability and workmen compensation coverage and workers compensation reports and/or filings.

E. The state fire marshal or his representative(s) may require that a firm or its employee(s) demonstrate a proficiency to use the necessary equipment to properly certify, inspect, install, integrate, maintain or service special locking systems and equipment. Proficiency shall be deemed to be achieved if the system or equipment complies with the applicable NFPA code or standard and/or manufacturer's specifications.

F. For those firms or their employee(s) which do not possess the proper equipment, tools and manuals or who fail to demonstrate the ability to properly perform the required work, then an order of correction shall be made to the contractor or his employee to obtain the required equipment, tools, NFPA codes, standards or manual or to obtain additional training within a specified time period. Another inspection shall be conducted by the state fire marshal or his representative to verify compliance with the order of correction. Good cause must be shown if proficiency is not shown or the required equipment, tools, NFPA codes, standards or manuals are not obtained by the time of the second inspection. Additional time may be granted for good cause. If good cause is not shown, then administrative action may be pursued.

G. The office may specifically enumerate additional required equipment or business records at a later date should it be deemed necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3257. Plan Review**

A. No special locking system requiring plan submittal in accordance with R.S. 40:1574 et seq., shall be installed prior to submitting plans with required documentation and receiving authorization to install such system from the Plan Review Section of the Office of the state fire marshal. However, the installation of wiring only for a special locking system shall be permitted upon receipt of plans and a project review number being issued by the Office of the State Fire Marshal, Plan Review Section. No system locks, devices or panels shall be installed prior to review or written authorization by the Office of the State Fire Marshal.

B. All submittals for plan review shall identify the licensed firm performing the installation and the responsible qualifier. The firm that is responsible for the installation of the locks shall be the firm listed as the installation firm.

C. Only listed qualifiers of a firm shall be listed on applications for full plan review or exemption to full plan review. Additionally, any correspondence regarding a submittal, to include but not be limited to, telephone, email or written correspondence, shall only be through a listed qualifier of the firm, owner of the firm, a professional of record or owner of the building.

D. A new plan review shall be required when a firm takes over a project in progress from another firm, listing the new firm's information and any changes to the project.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3259. Electrical Contractors**

A. All electrical contractors who have met all requirements and passed a prescribed written examination based upon National Fire Protection Association (NFPA) Code 70, the National Electrical Code, that has been given either by a recognized political subdivision of the State of Louisiana or by the State Licensing Board for Contractors, shall be authorized to install special locking systems, security, household fire and closed circuit television systems and equipment in accordance with manufacturer's specifications and applicable National Fire Protection Association (NFPA) codes as enumerated in LAC 55:V.103 and these rules.

B. The electrical contractor shall ensure that plans have been submitted and reviewed by the state fire marshal prior to installing any new or renovated special locking system. The system shall be certified by a property protection contractor upon the completion of the installation.

C. Electrical contractors are not permitted to certify, inspect or service special locking systems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

### **§3261. Miscellaneous Provisions**

A. Marking of vehicles. All service vehicles owned or operated by firms or their employees used for regulated activities, as defined by R.S. 40:1664.1 et seq., and these rules shall have the firm name, firm certificate number and firm telephone number permanently inscribed, painted, stenciled or affixed by magnetic means on such vehicles.

Such markings shall be a minimum of two and one-half inches in height and not less than one-fourth inch in width. Letters and numbers shall be on a contrasting background and be conspicuously seen from the outside of the vehicle. This requirement does not prevent a firm to use an unmarked vehicle on special occasions where covert work is required.

**B. Restrictions**

1. Certificate or license holders are not agents or representatives of the State of Louisiana, the Department of Public Safety or the Office of the State Fire Marshal. No claims or inferences of such shall be made.

2. A certificate or license does not authorize anyone to enforce these rules or to enter any building without the owner's permission or to engage in property protection activity without the owner's permission.

3. Certificate and license holders shall not allow the use of their certificate or licenses by other firms, persons or employees.

4. A license holder shall not perform any property protection activity unless employed by and within the course and scope of that employment with a firm regulated by the provisions of R.S. 40:1664.1 et seq.

5. A person shall not perform any act for which a certificate or license is required unless:

- a. first being certified or licensed to perform such acts; and
- b. is employed by a firm certified to perform those acts; and
- c. is performing those acts for the certified firm by which he is employed.

6. An apprentice, as defined in these rules, shall not perform any activity regulated by R.S. 40:1664.1 et seq., unless employed by a certified firm and directly supervised by a license holder authorized to perform such act or acts. Both the apprentice and licensee shall be employed by the same certified firm.

7. Nothing in these rules shall prevent an appropriately certified firm or licensed person from

certifying, inspecting, installing, integrating, maintaining, selling, or servicing any manufacturer's system or equipment.

**C. Multiple Names and Locations**

1. If a firm uses multiple names (i.e. trade or "doing business as" names), it must apply for a separate certificate of registration for each name if the firm name has a separate state or federal tax number. If the firm name does not have a separate state or federal tax number, then it shall be permitted to be registered with the firm's primary name. Only one trade or "doing business as" name shall be permitted to be registered along with the firm's primary name. Any other name that the firm wishes to use must have its own certificate of registration and must meet all licensing requirements as a separate and independent firm.

2. If a firm uses multiple locations, each location must apply for and receive its own certificate of registration. Each location is considered a separate firm and must meet all licensing requirements for firms.

3. If a firm advertises telephone numbers for dispatch purposes in various locations but has no physical office in those locations, then the advertisement must indicate "For Dispatch Only."

**D. Special Locking System Required Certification**

1. A building owner shall ensure that each special locking system within his commercial business is certified annually. Only the following systems as outlined in NFPA 101 shall require an annual certification:

- a. electronically controlled egress door assemblies;
- b. health care locking systems;
- c. delayed egress systems;
- d. access controlled systems;
- e. elevator lobby exit access door assembly locking systems;
- f. pedestrian gate systems; and
- g. detention locking systems.

2. Special locking systems shall be certified by a firm with the appropriate endorsement as follows:

Type of Endorsement	Type of System						
	Electronically Controlled Egress Door Assemblies	Health Care Locking Systems	Access Control Systems	Delayed Egress Systems	Elevator Lobby Exit Access Door Assembly Locking Systems	Pedestrian Gate Systems	Detention Locking Systems
Security	Yes	Yes	Yes	Yes	Yes	Yes	No
Locksmith	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Special Locking	Yes	Yes	Yes	Yes	Yes	Yes	No
Gate Systems	No	No	No	No	No	Yes	No
Detention Locking	No	No	No	No	No	No	Yes

3. For the purpose of determining the exact date of a required certification, the following guidelines shall apply: where only the year is known but not the month, January shall be used for the month, where the month is known but not the day, the first day of the month shall be used.

4. Annual certifications must be performed between 30 days prior and 30 days after the previous year's certification date.

5. The certified firm shall not be responsible for more frequent inspections as required by the applicable engineered specifications, manufacturer's specifications or per the inspection, testing and maintenance chapters as set forth in

the applicable NFPA codes and standards unless under contract to perform such.

E. Advertising. All advertising indicating property protection activity within Louisiana, including but not limited to telephone advertising, bids, letter head and business cards, shall indicate a firm's certificate of registration number, the firm's physical address and local telephone number. Yard signs must include the firm's certificate of registration number and may include a monitoring station telephone number. They do not need to include the firm's local telephone or physical address.

F. Service Invoices and Inspection Reports. All service invoices or inspection reports shall reflect the inspection,

installation, integration, maintenance, or service performed, all parts replaced, date of service, the firm name, the firm certificate number, the technician's name who performed the work and the technician's license number.

**G. Locking Service Record Keeping**

1. A locksmith who bypasses, manipulates, or originates a first key by code for a device safeguarding an area where access is meant to be limited, whether or not for compensation, shall document:

- a. where the work was performed;
- b. the name, address, date of birth, telephone number, and driver's license number or other identification number of the person requesting the work to be done; and
- c. the signature of that person.

2. A copy of the work order form shall be kept by the licensed locksmith for a period of two years and shall include:

- a. the name and license number of the locksmith; or
- b. the name and identification number of the registered employee who performed the services.

3. Work order forms required to be kept under this Section shall be available for inspection upon written request made three days in advance by the state fire marshal or his representative(s) or a law enforcement agency.

4. A locksmith who bypasses, manipulates, or originates a first key for a motor vehicle, whether or not for compensation, shall document:

- a. the name, address, date of birth, telephone number, vehicle identification number, and driver's license number or other identification number of the person requesting entry; and
- b. the signature of that person.

5. A copy of the work order form shall be kept by the licensed locksmith for a period of two years and shall include:

- a. the name and license number of the locksmith; or
- b. the name and identification number of the registered employee who performed the services.

6. Work order forms required to be kept under this Section shall be available for inspection upon written request made three days in advance by the state fire marshal or his representative(s) or a law enforcement agency.

**H. Security System Panels, Factory Default Code Reset**

1. A security system owner who wishes to change security firms must notify the existing firm in writing of his wishes if he desires to have the panel program code reset. All financial obligations of the system owner to the existing firm must be met prior to firm being required to reset the panel program code to factory default.

2. The firm shall return the panel program code to factory default within five working days upon written notice by the system owner.

3. Where a panel program code cannot be reset to factory default, then the panel shall be cleared of its memory to allow complete reprogramming or the existing firm shall install a new control panel for the security system owner.

4. This provision does not apply to panels which are proprietary in nature and will not work unless monitored and/or maintained by the proprietary firm.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 40:1664.2 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:

**Family Impact Statement**

1. The effect of these rules on the stability of the family. These rules should not affect the stability of the family. The rules are only applicable to businesses which engage in life safety and property protection contracting, specifically, security and locking contractors pursuant to R.S. 40:1664.1 et seq.

2. The effect of these rules on the authority and rights of parents regarding the education and supervision of their children. These rules should not affect the authority and rights of parents regarding the education and supervision of their children. The rules are only applicable to businesses which engage in life safety and property protection contracting, specifically, security and locking contractors pursuant to R.S. 40:1664.1 et seq.

3. The effect of these rules on the functioning of the family. These rules should not affect the functioning of the family. The rules are only applicable to businesses which engage in life safety and property protection contracting, specifically, security and locking contractors pursuant to R.S. 40:1664.1 et seq.

4. The effect of these rules on family earnings and family budget. These rules should not affect family earnings and family budget. The rules are only applicable to businesses which engage in life safety and property protection contracting, specifically, security and locking contractors pursuant to R.S. 40:1664.1 et seq.

5. The effect of these rules on the behavior and personal responsibility of children. These rules should not affect the behavior and personal responsibility of children. The rules are only applicable to businesses which engage in life safety and property protection contracting, specifically, security and locking contractors pursuant to R.S. 40:1664.1 et seq.

6. The effect of these rules on the ability of the family or local government to perform the function as contained in the proposed rules. These rules do not require the family or local government to perform any function.

**Small Business Impact Statement**

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses. The agency additionally consulted with and obtained input from the regulated industries to which these rules apply.

**Public Comments**

Interested persons may submit written comments on these proposed rules to DSFM Boyd Petty at 8181 Independence Blvd., Baton Rouge, LA 70806. Comments will be accepted through close of business on February 16, 2011.

### Public Hearing

A public hearing is scheduled for Friday, February 18, 2011 at 8181 Independence Blvd., Baton Rouge, LA 70806. Please call and confirm meeting date and location as the meeting will be cancelled if the required number of requests is not received.

Jill P. Boudreaux  
Under Secretary

### FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Property Protection Licensing

#### I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Implementation costs would be limited to the cost of copying the new rules and advertising in the *Louisiana Register*. The proposed rules provide for regulation of property protection contractors based on the provisions of Act 307 of the 2007 Regular Session. Property protection contractors are currently licensed and regulated based on the provisions of Act 307 of 2007, without any formal rules. With the exception of the proposed rules mandating the marking of all vehicles utilized by property protection contractors, the rules proposed mirror current licensing and regulation practices. Although encouraged, the marking of contractor vehicles is currently optional.

#### II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There is no direct material effect on governmental revenues as a result of the proposed rules. No new fees are proposed. Revenue from fees and fines are currently being collected and deposited according to provisions in existing statutes.

#### III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Property protection contractors utilizing unmarked vehicles will incur a one-time minimum expense (\$10–\$15 per vehicle) for the marking of unmarked vehicles. The number of unmarked vehicles is not known, but is estimated to be less than 20 percent of the approximately 400 licensed property protection contractors. A marked vehicle includes the name of the company and a fire marshal supported license number.

#### IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Adoption of the proposed rules is anticipated to enable all property protection contractors to be able to compete on an equal level.

Jill P. Boudreaux  
Undersecretary  
1101#065

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

### NOTICE OF INTENT

### Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Public Seed Grounds East of the Mississippi River and  
Oyster Lease Relocation (LAC 76:VII.511 and 531)

The Wildlife and Fisheries Commission does hereby give notice of its intent to establish the following administrative rules to modify the public oyster seed grounds east of the Mississippi River and for the efficient and effective relocation of oyster leases which were not renewed due to such leases being wholly contained within a public oyster seed ground. This Notice of Intent shall supplant and supersede that Notice of Intent approved by the Wildlife and Fisheries Commission on December 2, 2010 and published in the *Louisiana Register*, Volume 36, Number 12, December 20, 2010. Authority to designate public oyster seed grounds is vested in the Wildlife and Fisheries Commission by Louisiana Revised Statutes (R.S.) 56:434. Authority to develop rules for oyster lease relocation is vested in the Wildlife and Fisheries Commission by Act 265 of the 2010 Regular Legislative Session.

The Secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and the final Rule, including but not limited to, the filing of the Fiscal and Economic Impact Statement, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

#### Title 76

#### WILDLIFE AND FISHERIES

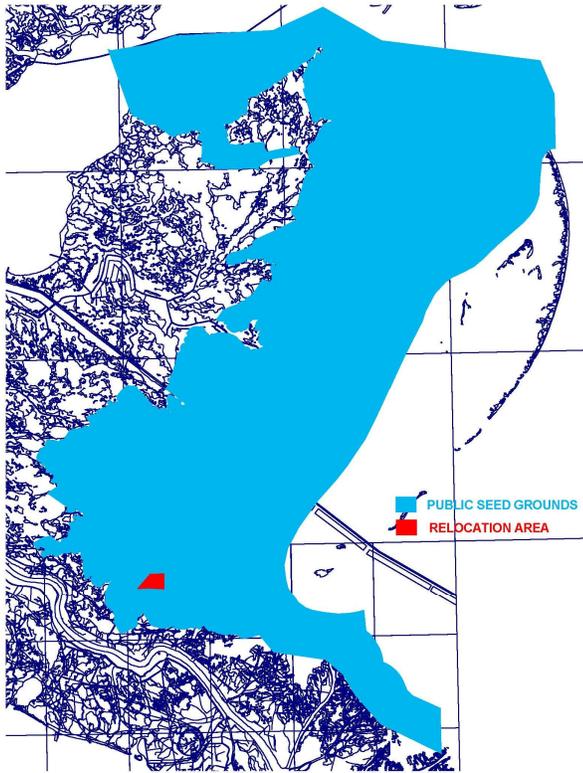
#### Part VII. Fish and Other Aquatic Life

#### Chapter 5. Oysters

#### §511. Public Oyster Seed Grounds East of the Mississippi River

A. The Public Oyster Seed Grounds East of the Mississippi River are described as that portion of state water bottoms hatched on the map below, except for that portion as described in Louisiana Administrative Code (LAC) 76:VII.531.B (Oyster Lease Relocation) and more particularly described as that area within the following coordinates (North American Datum 1983):

1. 89 degrees 27 minutes 49.74 seconds W  
29 degrees 27 minutes 48.91 seconds N
2. 89 degrees 26 minutes 36.54 seconds W  
29 degrees 27 minutes 48.89 seconds N
3. 89 degrees 26 minutes 36.47 seconds W  
29 degrees 26 minutes 38.48 seconds N
4. 89 degrees 28 minutes 04.69 seconds W  
29 degrees 26 minutes 43.66 seconds N
5. 89 degrees 28 minutes 58.49 seconds W  
29 degrees 26 minutes 41.69 seconds N



AUTHORITY NOTE: Promulgated in accordance with R.S. 56:434.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Office of Coastal and Marine Resources, LR 14:716 (October 1988), amended by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 37:

**§531. Oyster Lease Relocation**

A. Eligibility. Those leases which are currently located wholly within a public oyster seed ground, and any former leases which were determined by the Department of Wildlife and Fisheries to have been non-renewed since 1998 due to the fact that such leases were wholly contained within a public oyster seed ground, shall be eligible for relocation.

B. Area of Relocation. The below described area, recommended by the Department of Wildlife and Fisheries and approved by the Office of Coastal Protection and Restoration, in consultation with the Louisiana Oyster Task Force, is hereby set aside from the Public Oyster Seed Grounds east of the Mississippi River, as described in Louisiana Administrative Code (LAC) 76:VII.511. This area is more particularly described as that area within the following coordinates (North American Datum 1983):

1. 89 degrees 27 minutes 49.74 seconds W  
29 degrees 27 minutes 48.91 seconds N
2. 89 degrees 26 minutes 36.54 seconds W  
29 degrees 27 minutes 48.89 seconds N
3. 89 degrees 26 minutes 36.47 seconds W  
29 degrees 26 minutes 38.48 seconds N
4. 89 degrees 28 minutes 04.69 seconds W  
29 degrees 26 minutes 43.66 seconds N
5. 89 degrees 28 minutes 58.49 seconds W  
29 degrees 26 minutes 41.69 seconds N

C. Amount Lease Acreage Available. Any new lease issued under this relocation program shall be for an amount

of acreage not to exceed the acreage of the lease which is being relocated.

D. Notification and Application Process. The Department of Wildlife and Fisheries shall notify the leaseholder of an affected existing lease, or the leaseholder of record for a lease that was previously not renewed, of the option to relocate the lease. The affected leaseholder or leaseholder of record shall have 60 days from the date of notification to appear in person at the LDWF Oyster Lease Survey Section office to apply for a relocation lease. Applications shall be on application forms provided by the department and shall be processed by the department in the order in which they are received by the department.

E. Deceased Leaseholders. Any person or entity desiring to exercise the relocation rights of an otherwise eligible deceased applicant must present a valid "letter of administration" or "judgment of possession" in order to exercise the relocation rights provided in this Section.

F. Partitioning of Leases. Any qualifying leasehold person or entity who requests to have his rights in a qualifying lease partitioned into two or more leases within the relocation area shall provide to the LDWF Oyster Lease Survey Section a valid court order designating such persons or entities, and their respective percentage of lease relocation rights.

G. Issuance of Relocated Leases. Relocated leases shall be issued pursuant to LAC 76:VII.501 and 503.

H. Expiration Date. This Rule shall expire on January 1, 2013.

AUTHORITY NOTE: Promulgated in accordance with Act 265 of the 2010 Regular Legislative Session.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 37:

**Family Impact Statement**

In accordance with Act 1183 of 1999, the Department of Wildlife and Fisheries/Wildlife and Fisheries Commission hereby issues its Family Impact Statement in connection with the preceding Notice of Intent: This Notice of Intent will have no impact on the six criteria set out in R.S. 49:972(B).

**Public Comments**

Interested persons may submit written comments relative to the proposed Rule until 4:30 p.m., March 6, 2011 to Patrick D. Banks, LDWF Fisheries Division, Box 98000, Baton Rouge, LA 70898-9000.

Stephen J. Oats  
Chairman

**FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES**

**RULE TITLE: Public Seed Grounds East of the Mississippi River and Oyster Lease Relocation**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)**

Implementation of the proposed rule will be carried out using existing staff and funding level. Due to the limited number of leases that are eligible to participate in this oyster lease relocation program, the increase in costs, workload and paperwork to the state associated with implementing the proposed rule is anticipated to be minimal. Local governmental units will not be impacted.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Since 1998, there have been 16 oyster leases (568 acres) located in public oyster grounds that have not been renewed. The department receives \$2.00 per acre per year, which is deposited into the Conservation Fund. Thus, if all of the lease acres were relocated and renewed, the department could see a minimal increase in state revenue collections. A significant increase is unlikely to occur, since a large number of leases have been expired for over 10 years.

In addition, there are three oyster leases (131 acres) located in public oyster grounds that will expire within the next three years and will not be renewed.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Holders of oyster leases that are currently located within a public oyster seed ground and any former leases which were determined by the Department of Wildlife and Fisheries to have been non-renewed since 1998 due to the fact that such leases were located within a public oyster seed ground may benefit from the proposed rule. They will be eligible to relocate or exchange their non-renewal lease acres with equal acres located in other designated areas of the state during the current lease moratorium. The economic benefit derived from the proposed rule cannot be determined at this time and will depend on the productivity of the new leased areas compared to the productivity of the non-renewal oyster lease areas.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule is anticipated to have little or no effect on competition or employment in the public or private sectors.

Lois Azzarello  
Undersecretary  
1101#062

Evan Brasseaux  
Staff Director  
Legislative Fiscal Office

**NOTICE OF INTENT**

**Workforce Commission  
Office of Workers' Compensation**

**Medical Guidelines (LAC 40:I.Chapters 20-23)**

Notice is hereby given, in accordance with R.S. 49:950 et seq., that the Louisiana Workforce Commission, Office of Workers' Compensation, pursuant to authority vested in the Director of the Office of Workers' Compensation by R.S. 23:1310.1 and in accordance with applicable provisions of the Administrative Procedure Act, proposes to enact LAC 40:I., Subpart 2, Chapters 20-23 to add the following:

Chapter 20 (Spine Medical Treatment Guidelines): Sections 2001 through 2012 (Cervical Spine Injury), Sections 2013 through 2024 (Low Back Pain);

Chapter 21 (Pain Medical Treatment Guidelines): Sections 2101 through 2116 (Chronic Pain Disorder), Sections 2117 through 2136 (Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy);

Chapter 22 (Neurological and Neuromuscular Disorder Medical Treatment Guidelines): Sections 2201 through 2214 (Carpal Tunnel Syndrome), Sections 2215 through 2228 (Thoracic Outlet Syndrome);

Chapter 23 (Upper and Lower Extremities Medical Treatment Guidelines): Sections 2301 through 2314 (Lower

Extremities), Sections 2315 through 2328 (Shoulder Injuries).

The contents of the new chapters are relative to medical treatment guidelines for the delivery of medical treatment in workers compensation cases, which are being promulgated in accordance with the directives of R.S. 23:1203.1. The proposed enactment is set forth in the attached documents.

The full text of this Notice of Intent can be found in the Emergency Rule section of this issue of the *Louisiana Register*.

**Family Impact Statement**

1. The Effect on the Stability of the Family. The proposed medical guideline rules for the Office of Workers' Compensation Administration will have no effect on the stability of the family.

2. The Effect on the Authority and Rights of Parents Regarding the Education and Supervision of their Children. The proposed medical guideline rules for the Office of Workers' Compensation Administration will have no effect on the authority and rights of parents regarding the education and supervision of their children.

3. The Effect on the Functioning of the Family. The proposed medical guideline rules for the Office of Workers' Compensation Administration will have no effect on the functioning of the family.

4. The Effect on Family Earnings and Family Budget. The proposed medical guideline rules for the Office of Workers' Compensation Administration will have no effect on family earnings and family budget.

5. The Effect on the Behavior and Personal Responsibility of Children. The proposed medical guideline rules for the Office of Workers' Compensation Administration will have no effect on the behavior and personal responsibility of children.

6. The Ability of the Family or a Local Government to Perform the Function as Contained in the Proposed Rule. The family or a local government is not able to perform the functions contained in the proposed medical guideline rules for the Office of Workers' Compensation Administration.

**Public Comments**

Interested persons may submit data, views, arguments, information or comments on the proposed enactment in writing, to the Louisiana Workforce Commission, P.O. Box 94094, Baton Rouge, LA 70804-9094, Attention: Larry White, Director, Office of Workers' Compensation Administration. Written comments must be submitted and received by the department within 20 days from the date of this publication. A request pursuant to R.S. 49:953(A)(2) for oral presentation, argument or public hearing must be made in writing and received by the department within 20 days of the date of this publication.

Curt Eysink  
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT  
FOR ADMINISTRATIVE RULES  
RULE TITLE: Medical Guidelines**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The development of medical guidelines is required as the result of the passage of Act 254 (2009 Regular Legislative

Session) and Act 619 (2010 Regular Legislation Session). There were no additional administrative costs associated with the passage of these laws. However, a medical director was placed under contract by the Louisiana Workforce Commission to assist in the creation of the guidelines. The agency has absorbed these costs into its existing budget along with any future medical professional contracts that may be necessary in conjunction with these guidelines or Acts. The promulgation of the proposed medical guidelines simply identify the guidelines to be followed by the parties in compliance with LA. R.S. 23:1203.1. As such, the promulgation of these rules is not expected to provide any additional costs or savings for the Office of Workers' Compensation.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The implementation of medical guidelines, in accordance with La. R.S. 23:1203.1, should have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The implementation of evidence based medical treatment guidelines, in accordance with La. R.S. 23:1203.1, is expected to streamline the process for delivery of medical services to injured workers, as well as the process for resolution of disputes related to delivery of medical services. With such an improved process, it is expected that medical outcomes will improve resulting in injured workers returning to gainful employment more quickly. However, an estimation of the specific economic benefits would be conjecture as there is no empirical evidence currently available related to the specific guidelines being proposed for the State of Louisiana.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated effect on competition and employment.

Chris Broadwater  
Director  
1101#019

Robert E. Hosse  
Staff Director  
Legislative Fiscal Office

# Administrative Code Update

CUMULATIVE: JANUARY - DECEMBER 2010

LAC Title	Part.Section	Effect	Location LR 36 Month Page	LAC Title	Part.Section	Effect	Location LR 36 Month Page
4	XI.101,103,105,107,109,111	Repealed	July 1544	28	VI.305,307,311	Amended	Nov. 2550
7	III.101,103	Amended	Mar. 464		VI.315	Amended	Sept. 2030
	III.301-315	Adopted	Mar. 464		IX.101,103,105,302,303,305,317	Amended	Dec. 2839
	III.301-337	Repealed	Feb. 231		IX.319,501	Amended	Dec. 2839
	XIII.101,113,191,207	Amended	June 1220		XXXI.503,507	Amended	Mar. 489
	XIII.222	Repealed	June 1220		XLI.101,301,501,503,505	Amended	July 1505
	XXI.339	Amended	Nov. 2518		XLI.507,701,901,903,1101,1103,1105	Amended	July 1505
	XXIII.143	Amended	Sept. 1980		XLI.601,603,605,607,609	Adopted	July 1505
	XXIX.117,119	Amended	Nov. 2520		XLI.1107,1301	Amended	July 1505
10	XII.301	Repealed	Feb. 316		XLI.151,152,153,160,301	Amended	July 1499
	XVII.901	Amended	June 1243		XLI.230,607,802,803	Adopted	July 1499
13	I.2701,2703,2705,2709	Adopted	Feb. 307		XLI.512,601,603,705,905	Amended	July 1499
	I.2711,2713,2715	Adopted	Feb. 307		XLI.1101,1102,1103,1105	Adopted	Sept. 2011
	I.2707,2717	Adopted	Feb. 307		XLI.1107,1117,1118,1129	Adopted	Sept. 2011
	I.2901,2905	Amended	Aug. 1768		XLI.1130,1132,1133,1149	Adopted	Sept. 2011
	I.2904	Adopted	Aug. 1768		XLI.1151,1152,1153,1156	Adopted	Sept. 2011
	I.2907,2909	Repealed	Aug. 1768		XLI.1167,1173,1174,1230	Adopted	Sept. 2011
	I.Chapter 35	Adopted	Mar. 474		XLI.1301,1303,1305,1320	Adopted	Sept. 2011
	I.Chapter 37	Adopted	Apr. 750		XLI.1321,1322,1324,1325,1326	Adopted	Sept. 2011
	I.Chapter 39	Adopted	Nov. 2543		XLI.1327,1328,1501,1502	Adopted	Sept. 2011
	III.1709	Amended	Jan. 51		XLI.1503,1504,1507,1508	Adopted	Sept. 2011
19	II.105,107,507,903	Amended	Jan. 51		XLI.1509,1510,1511,1512	Adopted	Sept. 2011
	IX.Chapters 1 and 3	Adopted	Mar. 471		XLI.1513,1515,1516,1517	Adopted	Sept. 2011
	IX.Chapters 11 and 13	Adopted	Mar. 507		XLI.1518,1519,1520,1602	Adopted	Sept. 2011
22	I.103	Amended	Mar. 525		XLI.1603,1604,1701,1702	Adopted	Sept. 2011
	I.103	Repealed	Dec. 2873		XLI.1901,1902,1903,1904	Adopted	Sept. 2011
	I.105	Amended	May 1017		XLI.2001	Adopted	Sept. 2011
	I.107	Amended	Mar. 528		XLV.501,601	Amended	Apr. 753
	I.109	Amended	Mar. 534		XXXIX.101,103,301,303,305	Amended	Sept. 2001
	I.317	Amended	Nov. 2572		XXXIX.501,503,505,507,509	Amended	Sept. 2001
	I.319	Adopted	Mar. 533		XXXIX.511,513,901,903,905	Amended	Sept. 2001
	I.331	Amended	Mar. 531		XXXIX.701,703,705,707	Adopted	Sept. 2001
	I.339	Amended	June 1265		XXXIX.907,909,911,913,915	Amended	Sept. 2001
	I.351,363	Amended	Dec. 2873		XXXIX.1101	Amended	Sept. 2001
	I.363	Amended	Oct. 2289		XXXIX.1301,1501	Repealed	Sept. 2001
	I.723	Adopted	Aug. 1784		LXXIX.107,115,905,2103,3303	Amended	Dec. 2847
	I.2101	Amended	Aug. 1784		LXXIX.305	Amended	Dec. 2849
	I.2103,2105	Repealed	Aug. 1784		LXXIX.2109,2323	Amended	Dec. 2849
	I.2327	Repealed	Mar. 525		LXXIX.2111	Amended	July 1498
	III.4703	Amended	May 992		LXXXIII.301,303,307,405,409	Amended	Sept. 1987
	XI.103,503,511,1301	Amended	Dec. 2871		LXXXIII.302	Adopted	Oct. 2241
	XIII.301	Amended	Oct. 2278		LXXXIII.313,511,513,514,525	Repealed	Sept. 1987
	XV.901-927	Adopted	May 993		LXXXIII.411,413,515,519,521	Amended	Sept. 1987
25	I.1103-1119	Amended	Mar. 469		LXXXIII.603,611,613,708	Amended	Oct. 2241
	V.501,503,505,507	Adopted	Jan. 50		LXXXIII.603,611,701	Amended	Dec. 2841
	VII.101,103,107,301,305,501	Amended	Nov. 2537		LXXXIII.613	Repromulgated	Sept. 1994
	VII.505,507,1301,1303,1305	Amended	Nov. 2537		LXXXIII.613,1101,1601,4311	Amended	Aug. 1769
	VII.2305,3101,3103,3105,3113,4303	Amended	Nov. 2537		LXXXIII.703,903,3301,3303	Amended	Sept. 1987
	VII.4501,4507,5103,5301,5305	Amended	Nov. 2537		LXXXIII.2701,2702,2703,2705	Repealed	Sept. 1987
	IX.101,301,303,307,308,309	Amended	June 1225		LXXXIII.2707,2709,2711,2713	Repealed	Sept. 1987
	IX.310,312,313,314,321,331	Amended	June 1225		LXXXIII.2715,2717,2719,2721	Repealed	Sept. 1987
	IX.500,501,502,504,505,506	Amended	June 1225		LXXXIII.3701,3901,4310,4503	Amended	Sept. 1987
	IX.507,900,901,903	Amended	June 1225		LXXXIII.4001,4003	Amended	Oct. 2241
	IX.905,907,909,911,913,915	Repealed	June 1225		LXXXIII.4505	Repealed	Sept. 1987
	IX.917,919	Repealed	June 1225		LXXXIII.5101,5103	Amended	Aug. 1769
	IX.921,923,925,927,929,931	Adopted	June 1225		CXI.107,1803,1813,1817	Amended	Mar. 477
28	I.313,501,503	Amended	Dec. 2850		CXI.312,701,1127,1129,1151	Amended	May 967
	I.713	Amended	Jan. 59		CXI.1325,1327,1349,1803	Amended	May 967
	IV.301,507,703	Amended	Feb. 311		CXI.1819,1821,1823,1825	Adopted	May 967
	IV.301,701,703,705,801,803,1901	Amended	Dec. 2854		CXI.1827,1829,2031,2033	Adopted	May 967
	IV.301,703,705,803	Amended	Mar. 490		CXI.2011,2012,2013,2014	Amended	May 967
	IV.709,803	Amended	Oct. 2269		CXI.2015,2016,2017,2019	Amended	May 967
	IV.1009,1011,1013,1015	Amended	Sept. 2029		CXI.2035,2037,2039,2041	Adopted	May 967
	IV.1017	Repealed	Sept. 2029		CXI.3303,3307,3501	Amended	May 967
	IV.1101,1103,1107,1109,1111	Amended	Oct. 2267		CXIII.101,301,303,305,307	Amended	July 1466
	IV.1203,1205,1207,1211,1213	Amended	Dec. 2852		CXIII.309,501,503,505,507	Amended	July 1466
	IV.1217	Amended	Dec. 2852		CXIII.701,901,903,905,907	Amended	July 1466
	IV.1603	Amended	Nov. 2550		CXIII.909,913,915,1101,1103	Amended	July 1466
	IV.Chapter 18	Adopted	Nov. 2547		CXIII.911,1705,1903,2507	Adopted	July 1466
	IV.1903	Amended	Dec. 2854		CXIII.1105,1301,1303,1305	Amended	July 1466
	VI.301	Amended	Feb. 313		CXIII.1307,1501,1503,1505	Amended	July 1466
	VI.305,311,315	Amended	Mar. 492		CXIII.1701,1703,1901,1905	Amended	July 1466
					CXIII.2101,2103,2105,2107	Amended	July 1466
					CXIII.2109,2111,2301,2303	Amended	July 1466
					CXIII.2305,2501,2503,2505	Amended	July 1466
					CXIII.2509,2515,2517,2701	Amended	July 1466
					CXIII.2511,2513,3103	Adopted	July 1466
					CXIII.2901,2903,3101	Amended	July 1466
					CXV.337,709,1103,1109,1301	Amended	June 1224



LAC Title	Part.Section	Effect	Location LR 36 Month Page	LAC Title	Part.Section	Effect	Location LR 36 Month Page	
46	XCI.301,311	Amended	Feb. 322	50	XIX.4501	Amended	Aug. 1781	
	XCI.303	Amended	June 1246		XXI.6101	Amended	Oct. 2281	
	XCI.901	Adopted	Feb. 321		XXI.11303,12101	Amended	Feb. 324	
48	I.6867	Amended	May 1008	XXI.12101	Amended	Oct. 2280		
	I.8807	Amended	Apr. 831	XXI.13704	Adopted	Jan. 65		
	I.9303	Amended	Mar. 513	XXI.14301	Amended	June 1247		
	I.Chapter 96	Adopted	Mar. 513	XXII.2701	Amended	Oct. 2279		
	I.9727	Amended	May 1013	XXV.503	Amended	Sept. 2039		
	I.9729	Amended	Feb. 325	XXVII.325	Amended	June 1248		
	I.12501,12503,12505,12525	Amended	Feb. 322	XXVII.325,353	Amended	Nov. 2564		
	I.12525	Adopted	Feb. 322	XXVII.571	Amended	Nov. 2564		
	I.12507	Amended	Oct. 2279	XXVII.573	Amended	Nov. 2565		
	I.12529	Amended	May 1009	XXIX.123,991	Adopted	Aug. 1782		
	I.Chapter 129	Adopted	Mar. 521	XXIX.901,925,935,945,949	Amended	July 1558		
	V.1101,1303,1305,1307	Amended	Jan. 68	XXIX.915,917,919,921,923	Adopted	July 1558		
	V.1309,1311,1313,1315	Adopted	Jan. 68	XXIX.963	Amended	July 1558		
	XIII.17101,17103,17105	Amended	Apr. 759	51	II.101,105,107,109,111,115	Amended	May 1014	
	XIII.17107,17109,17111	Amended	Apr. 759		II.105	Repromulgated	June 1253	
	XIII.17113,17115,17117	Amended	Apr. 759		VI.101	Amended	Oct. 2283	
	XIII.17119,17121,17123	Amended	Apr. 759		VI.125,127,129	Adopted	Oct. 2283	
	XIII.17125	Amended	Apr. 759	IX.327,329,331	Amended	May 1016		
	XXV.Chapter 5	Adopted	June 1255	XII.317	Adopted	Jan. 68		
	50	I.1101	Adopted	Nov. 2563	52	I.1312	Adopted	July 1463
I.1101,1103,1105,1107		Adopted	July 1555	I.1318,1319,1320		Amended	Feb. 232	
I.2915		Amended	Oct. 2279	I.1322		Adopted	Feb. 232	
I.Chapter 125		Adopted	Dec. 2865	I.1703	Adopted	Feb. 304		
II.501-511		Amended	May 1010	I.1703	Amended	July 1466		
II.10146,10157		Repealed	May 1010	55	I.Chapter 15	Amended	Mar. 550	
III.2325,10703		Adopted	Dec. 2867		I.1903,1905,1907,1911,1913,1931	Amended	Nov. 2575	
III.10705		Amended	Dec. 2867		I.1913	Amended	June 1270	
V.301		Adopted	Jan. 66		I.1930	Adopted	Nov. 2575	
V.953,955,959		Amended	July 1552		I.1933,1937,1939,1941,1947	Amended	Nov. 2575	
V.953,955,959		Amended	Nov. 2561		I.1947	Amended	Mar. 546	
V.954		Adopted	Mar. 519		I.Chapter 31	Adopted	Mar. 536	
V.967		Adopted	Nov. 2561		III.813	Amended	Aug. 1789	
V.2501		Amended	Jan. 65		V.103,303	Amended	July 1563	
V.2501		Amended	Mar. 512		V.2701,2703,2705,2707	Amended	May 1020	
V.2711		Amended	Aug. 1781		V.2713,2717,2719	Amended	May 1020	
V.5313,5513,5713,5913,6115		Amended	June 1250	V.2715	Adopted	May 1020		
V.5313,5513,5713,5913,6115		Amended	Sept. 2041	V.2721,2723,2729,2735	Amended	May 1020		
V.5315,5515,5717,5915,6117		Adopted	Dec. 2867	V.2725,2737	Adopted	May 1020		
V.5317,5517,5719,5917,6119		Adopted	Sept. 2041	VI.301	Amended	Nov. 2574		
V.6105		Adopted	Jan. 67	VI.505,701,703,705,707,901	Repromulgated	Feb. 326		
V.6105		Amended	Aug. 1782	55	VI.903	Repromulgated	Feb. 326	
VII.1305		Amended	July 1556		VI.905	Repealed	Feb. 326	
VII.1305		Amended	Aug. 1782		VI.905	Adopted	June 1271	
VII.1305		Amended	Nov. 2566		IX.103	Amended	Nov. 2571	
VII.1305,1309		Amended	Feb. 325	IX.301	Adopted	Nov. 2571		
VII.1305,1309		Amended	Mar. 520	58	I.3117	Adopted	Sept. 2050	
VII.32903		Amended	July 1555		XV.101	Adopted	Oct. 2290	
IX.501		Adopted	Jan. 68		XV.103	Adopted	Dec. 2865	
IX.15103		Repealed	June 1252		61	I.1125	Adopted	Oct. 2290
IX.15111		Repealed	June 1251			I.1525	Adopted	Dec. 2877
IX.15113		Adopted	June 1252			I.1601-1613	Adopted	Jan. 52
IX.15113		Amended	Oct. 2282			I.1631-1639	Amended	Feb. 304
IX.15131,15133,15135		Adopted	June 1251			I.1661,1663,1665,1667,1669	Amended	Sept. 1981
IX.15133		Adopted	Oct. 2282			I.1671,1673	Adopted	Sept. 1981
IX.15143		Adopted	Nov. 2566			I.1690,1691,1692,1693,1695	Repromulgated	Oct. 2236
XI.6901,6903		Amended	Sept. 2040	I.1697,1699		Repromulgated	Oct. 2236	
XI.7503		Amended	Oct. 2278	I.1701		Repealed	Feb. 329	
XI.10503		Amended	Oct. 2280	I.1907		Amended	Sept. 2047	
XIII.701		Amended	Oct. 2281	I.1909	Adopted	Aug. 1790		
XIII.8501,8503		Adopted	Mar. 512	I.4401	Amended	May 1028		
XIII.10301		Amended	June 1247	I.4401	Amended	July 1566		
XIII.10301		Amended	Sept. 2041	III.1525	Adopted	June 1271		
XV.401,403,405		Adopted	June 1249	III.2501	Amended	Jan. 72		
XV.901		Amended	June 1249	III.2503	Adopted	Mar. 552		
XV.901		Amended	Nov. 2565	III.5103	Repromulgated	Aug. 1767		
XV.6705		Amended	Apr. 759	V.101,303,304,703,901,907	Amended	Apr. 765		
XV.6905		Amended	Sept. 2040	V.1103,1305,1307,1503,2503	Amended	Apr. 765		
XV.7321		Amended	Nov. 2561	V.3101,3103,3105,3106,3107	Amended	Apr. 765		
XV.10701,11101,11103		Amended	Aug. 1783	67	I.201,203,301,303,305,307,309	Adopted	Apr. 850	
XV.12917		Amended	June 1251		III.201,12231229,1257,1501	Amended	Nov. 2523	
XV.16107		Amended	Sept. 2044		III.1701,1703,1709,1711,1713	Amended	Nov. 2523	
XV.25305		Adopted	Nov. 2565		III.1911,1913,1915,1917,1919	Amended	Nov. 2523	
XV.25701		Amended	June 1250		III.1921,1923,1927,1931,1935	Amended	Nov. 2523	
XV.25701		Amended	Nov. 2565		III.1932	Repealed	Nov. 2523	
XV.27501,27503,27701,27901		Adopted	July 1557		III.1934,5106,5501	Adopted	Nov. 2523	
XV.28101	Adopted	July 1557	III.1938,1940,1941,1945,1949		Amended	Nov. 2523		
XVII.301	Amended	Mar. 520	III.1951,1953,1961,1967,1969		Amended	Nov. 2523		
XVII.501	Repromulgated	Mar. 521	III.1975,1977,1978,1980,1981		Amended	Nov. 2523		
XVII.501	Amended	June 1253						
XVII.501	Amended	Nov. 2566						
XIX.4329,4334,4335,4337	Amended	June 1248						
XIX.4329,4334,4335,4337	Amended	Nov. 2563						

LAC Title	Part.Section	Effect	Location		LAC Title	Part.Section	Effect	Location		
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67	III.1983,1985,1987,1988,1991	Amended	Nov.	2523	67	V.6503,6705,6955,7107	Amended	July	1462	
	III.1993,1995,1997,1998,1999	Amended	Nov.	2523		V.6701-6717	Adopted	Apr.	784	
	III.2003,2005,2007,2013,2103	Amended	Nov.	2523		V.6703,6955	Amended	Nov.	2521	
	III.2105,2107,2113,2117,5102	Amended	Nov.	2523		V.6709	Repromulgated	May	1029	
	III.2301,2509,2801	Amended	Jan.	74		V.6901-6935	Repealed	Apr.	784	
	III.Chapter 51	Amended	Mar.	555		V.6953,6955,6959	Amended	Feb.	329	
	III.5102,5103,5104,5109	Amended	June	1277		V.6955	Repromulgated	May	1031	
	III.5102,5103,5105,5107,5109	Amended	Apr.	844		V.6955	Repromulgated	Dec.	2838	
	III.5104,5107,5113,5329,5347	Amended	Nov.	2523		V.7101-7123	Adopted	Apr.	784	
	III.5111	Repealed	Nov.	2523		V.7107	Adopted	Apr.	838	
	III.5121,7302,7303,7305,7355	Amended	Feb.	332		76	III.337	Adopted	June	1280
	III.5509	Amended	Oct.	2236			V.127	Amended	Jan.	74
	III.7302,7304,7355,7357	Amended	Apr.	847			V.131	Adopted	Apr.	852
	III.7303,7359	Amended	Apr.	831			V.305	Amended	Oct.	2291
	III.7303,7359	Repromulgated	June	1272			VII.199	Amended	June	1280
	III.7303,7359	Amended	June	1279			VII.329	Amended	Jan.	77
	III.7303,7359	Amended	Nov.	2521			VII.335	Amended	Aug.	1791
	III.7357,7359,7361	Amended	Feb.	332	VII.367		Amended	Jan.	77	
	V.1103,1105,6503,6705,6955	Amended	Apr.	838	VII.373		Adopted	May	1034	
	V.3501	Amended	Jan.	73	XIX.101,103		Amended	July	1580	
	V.Chapter 41	Adopted	Mar.	552	XIX.105		Amended	Sept.	2051	
	V.5701,5703,5705	Repealed	Nov.	2522	XIX.111		Amended	July	1566	
	V.5901,5903	Adopted	Nov.	2522	XIX.113		Amended	Nov.	2581	
	V.6101-6117,6901-6935	Repealed	Apr.	784	XIX.115		Amended	Nov.	2583	
	V.6103,6507,6703,6905,6955	Amended	Apr.	831						
	V.6103,6507,6703,6905,6955	Repromulgated	June	1272						
	V.6115,6709,6903,6905,6909	Amended	Feb.	329						
	V.6301-6341,6501-6569	Adopted	Apr.	784						

# Potpourri

## POTPOURRI

### Department of Agriculture and Forestry Horticulture Commission

#### Landscape Architect Registration Exam

The next landscape architect registration examination will be given June 13-14, 2011, beginning at 7:45 a.m. at the Nelson Memorial Building, Louisiana State University Campus, Baton Rouge, LA. The deadline for sending the application and fee is as follows.

New Candidates:	February 18, 2011
Re-Take Candidates:	March 18, 2011
Reciprocity Candidates:	April 22, 2011

Further information pertaining to the examinations may be obtained from Craig Roussel, Director, Horticulture Commission, P.O. Box 3596, Baton Rouge, LA 70821-3596, phone (225) 952-8100.

Any individual requesting special accommodations due to a disability should notify the office prior to March 18, 2011. Questions may be directed to (225) 952-8100.

Mike Strain, DVM  
Commissioner

1101#033

## POTPOURRI

### Department of Children and Family Services Economic Stability and Self-Sufficiency Section

#### Temporary Assistance to Needy Families (TANF)—Caseload Reduction Report for Louisiana

The Department of Children and Family Services, hereby gives notice that, in accordance with federal regulations at 45 CFR 261.40, the Temporary Assistance to Needy Families (TANF) Caseload Reduction Report for Louisiana is now available to the public for review and comment.

In order to receive a caseload reduction credit for minimum participation rates, the agency must submit a report based on data from the Family Independence Temporary Assistance Program (FITAP) and the Strategies to Empower People Program (STEP) containing the following information:

1. a listing of, and implementation dates for, all state and federal eligibility changes, as defined at 45 CFR 261.42, made by the state after FY 2005;
2. a numerical estimate of the positive or negative impact on the applicable caseload of each eligibility change (based, as appropriate, on application denials, case closures, or other analyses);
3. an overall estimate of the total net positive or negative impact on the applicable caseload as a result of all such eligibility changes;

4. an estimate of the state's caseload reduction credit;
5. a description of the methodology and the supporting data that it used to calculate its caseload reduction estimates;
6. a certification that it has provided the public an appropriate opportunity to comment on the estimates and methodology, considered their comments, and incorporated all net reductions resulting from federal and state eligibility changes; and
7. a summary of all public comments.

Copies of the TANF Caseload Reduction Report may be obtained by writing Tara Prejean, Department of Children and Family Services, P.O. Box 94065, Baton Rouge, LA 70804-9065, by telephone at (225)342-4096, or via e-mail at tara.prejean@la.gov.

Written comments regarding the report should also be directed to Ms. Prejean. These must be received by close of business on 30 days from January 20, 2011.

Ruth Johnson  
Secretary

1101#068

## POTPOURRI

### Office of the Governor Coastal Protection and Restoration Authority

#### Public Hearing—State Fiscal Year 2012 Draft Annual Plan

Pursuant to R.S. 49:213.6, the Coastal Protection and Restoration Authority of Louisiana (CPRA), will hold the following public hearings to receive comments and recommendations from the public and from elected officials on Louisiana's draft "Fiscal Year 2012 Annual Plan: Integrated Ecosystem Restoration and Hurricane Protection in Coastal Louisiana":

Tuesday, March 1, 2011, at 6:00 p.m.  
Lake Charles Civic Center  
Contraband Room  
900 Lakeshore Drive  
Lake Charles, LA 70601

Wednesday, March 2, 2011, at 6:00 p.m.  
St. Tammany Parish Government  
Council Chambers Room  
21490 Koop Drive  
Mandeville, LA 70471

Thursday, March 3, 2011, at 6:00 p.m.  
Terrebonne Parish Consolidated Government  
Government Tower Building  
Council Meeting Room, 2nd Floor  
8026 Main Street  
Houma, LA 70360

If, because of a disability, you require special assistance to participate, please contact the Office of Coastal Protection and Restoration, at P.O. Box 44027, Baton Rouge, LA 70804-4027 or by telephone at (225) 342-5160, at least five working days prior to the hearing.

The contact for all meetings is at (225) 342-4123 or (225) 342-5160.

Please visit <http://coastal.louisiana.gov> for more detailed information and a copy of the draft Annual Plan which will be posted prior to the public meetings.

For questions regarding the meetings, please contact Karim Belhadjali at (225) 342-4123.

Garret Graves  
Chairman

1101#045

**POTPOURRI**

**Department of Health and Hospitals  
Office of Public Health**

**Notice of Public Hearing—Preventive Health and Health  
Services Block Grant**

The Department of Health and Hospitals, Office of Public Health, will hold a public hearing to receive input from the public on the Louisiana Preventive Health and Health Services Block Grant as administered by the agency. The scheduled public hearing will take place on Monday, February 28, 2011 beginning at 9 a.m. at 628 North Fourth Street (Bienville Building), 3rd floor, Room 372, Baton Rouge, LA 70802. Copies of the grant may be obtained from Avis Richard-Griffin, Policy, Planning and Evaluation, Office of Public Health. Ms. Richard-Griffin can be contacted by email at [avis.richard-griffin@la.gov](mailto:avis.richard-griffin@la.gov) or by telephone at (225) 342-9355 for additional information.

Bruce Greenstein  
Secretary

1101#048

**POTPOURRI**

**Department of Natural Resources  
Office of Conservation**

**Orphaned Oilfield Sites**

Office of Conservation records indicate that the oilfield sites listed in the table below have met the requirements as set forth by section 91 of Act 404, R.S. 30:80 et seq., and as such are being declared Orphaned Oilfield Sites.

Operator	Field	District	Well Name	Well Number	Serial Number
O.S. Golden	Wildcat-No La Shreveport Dist	S	Cranford	001	15930

Operator	Field	District	Well Name	Well Number	Serial Number
Mouse River Partnership	Kings Ridge	L	Lydia Harrison	001	95184
Skinner Energy Management Inc.	Longwood	S	E M Griffith	001	158438
Skinner Energy Management Inc.	Longwood	S	VUA;Powell	001	216528
Skinner Energy Management Inc.	Longwood	S	Powell	002	216529
Skinner Energy Management Inc.	Longwood	S	VUB; Templeton	001	216530
Skinner Energy Management Inc.	Longwood	S	VUC; P A Sharp	001	217182
Skinner Energy Management Inc.	Longwood	S	VUE; Breard	001	217462
Skinner Energy Management Inc.	Longwood	S	VUD; W L Sharp	001	217463
Skinner Energy Management Inc.	Longwood	S	VUF; Breard	002	217464
Skinner Energy Management Inc.	Longwood	S	VUF; Breard	003	217582
Skinner Energy Management Inc.	Longwood	S	Wheeler	001	218328
Skinner Energy Management Inc.	Longwood	S	Templeton A	003	221002

James H. Welsh  
Commissioner

1101#032

**POTPOURRI**

**Department of Natural Resources  
Office of Conservation**

**Public Hearing—Legal Notice, Docket No. ENV 2011-02**

Notice is hereby given that the Commissioner of Conservation will conduct a hearing at 6 p.m., Wednesday, March 2, 2011, at the Government Tower Building located at 8026 Main Street, Second Floor Meeting Room, Houma, LA.

At such hearing, the commissioner, or his designated representative, will hear testimony relative to the application of Vanguard Environmental, LLC, P O Box 4276, Houma, LA 70361. The applicant requests approval from the Office of Conservation to construct and operate a commercial deep well injection waste disposal facility for disposal of exploration and production waste (E and P Waste) fluids located in Township 17 South, Range 17 East, Section 15 in Terrebonne Parish.

The application is available for inspection by contacting Mr. Daryl Williams, Office of Conservation, Environmental Division, eighth floor of the LaSalle Office Building, 617 North Third Street, Baton Rouge, LA. Copies of the application will be available for review at the Terrebonne Parish Consolidated Government Council's Office or the Main Branch Public Library in Houma, LA. Verbal information may be received by calling Mr. Williams at (225) 342-7286.

All interested persons will be afforded an opportunity to present data, views or arguments, orally or in writing, at said public hearing. Written comments which will not be presented at the hearing must be received no later than 4:30 p.m., Wednesday, March 9, 2011, at the Baton Rouge Office. Comments should be directed to:

Office of Conservation  
Environmental Division  
P.O. Box 94275  
Baton Rouge, LA 70804  
Re: Docket No. ENV 2011-02  
Commercial Facility Well Application  
Terrebonne Parish

James H. Welsh  
Commissioner

1101#046

**POTPOURRI**  
**Department of Natural Resources**  
**Office of the Secretary**  
**Fishermen's Gear Compensation Fund**

Loran Coordinates

In accordance with the provisions of R.S. 56:700.1 et seq., notice is given that 5 claims in the amount of \$15,334.83 were received for payment during the period December 1, 2010-December 31, 2010.

There were 5 paid and 0 denied.

Latitude/Longitude Coordinates of reported underwater obstructions are:

2914.029	9118.636	Terrebonne
2915.241	9054.232	Terrebonne
2931.950	9218.600	Vermilion
2936.517	8943.529	Plaquemines

A list of claimants and amounts paid can be obtained from Gwendolyn Thomas, Administrator, Fishermen's Gear Compensation Fund, P.O. Box 44277, Baton Rouge, LA 70804 or you can call (225) 342-0122.

Scott A. Angelle  
Secretary

1101#052

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